



## Human Resources

### Employee Benefits and Services



# 2015-16 Employee Benefits Guide

*Working Toward a Healthier You*



# Open Enrollment

## Tips

- ✓ Visit <http://mybenefitsatwork> to learn more about your benefit options or to view a recorded Open Enrollment meeting
- ✓ Review What's New & Different For Plan Year 2015-16 for important changes that may be of interest to you (page 2)
- ✓ Check important dates (page 3) and Open Enrollment meeting schedule (page 6)
- ✓ Enroll or make changes using the eBenefits online Open Enrollment system at <https://emacsaapp.sbcounty.gov/psp/h90prd/?cmd=login>. Step-by-step instructions begin on page 14
- ✓ Select the right coverage level. Review the medical and dental plan highlights and comparison charts (pages 18-45) and life insurance information (pages 62-66)
- ✓ Enroll or re-enroll in the Medical Expense Reimbursement Plan (FSA) (pages 50-54)
- ✓ Review additional benefits that may be available to you (pages 76-79)
- ✓ Don't delay — enroll or make your changes before June 19, 2015
- ✓ Submit any additional required documentation to EBSD by Monday, July 6, 2015

Detailed benefit plan information and more can be found in this guide or online at:

<http://mybenefitsatwork> | (909) 387-5787 | [ebds@hr.sbcounty.gov](mailto:ebds@hr.sbcounty.gov)

**Open Enrollment is June 1 through June 19, 2015**

*You are encouraged to keep this guide throughout the year.*

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## AS YOU ENROLL

This guide is designed to help you understand your Benefit Enrollment options for plan year 2015-16. Benefit elections will become effective July 25, 2015. Included are summaries of your plan choices, such as medical, dental, vision, life insurance, accidental death & dismemberment and retirement options. Benefits vary depending on the bargaining unit that you belong to, so please check your applicable benefit summary for details at <http://countyline/hr/benefits/mybenefitsbyunit/home.asp> or your Memorandum of Understanding (MOU), Exempt Compensation Plan, Salary Ordinance, or Employment Contract. You will also find in this benefits guide, comparison charts for convenient at-a-glance referencing and plan contact information. Please read your materials carefully, and choose the plans that best meet your needs.

We encourage you to use this guide as a reference throughout the year. If you have questions, contact the Employee Benefits and Services Division (EBSD) or the plan providers directly. Plan phone numbers and web sites are listed in the Contact Information section on page 5 of this guide.



### Dependent Election Proof

If your open enrollment election includes the addition of new dependents not currently or previously enrolled in a County plan, the deadline to submit proof of dependency is Monday, July 6, 2015. If EBSD does not receive dependent documentation by 5:00 p.m. on July 6, 2015, your dependent(s) will not be added to your plan for the 2015-16 plan year.

Additionally, if you are adding a dependent(s) who is mentally or physically disabled and is 26 years or over, you must indicate their status as disabled online using eBenefits.

## WHAT'S NEW & DIFFERENT FOR PLAN YEAR 2015-16

*The following is a summary of significant changes:*

### SHORT-TERM & LONG-TERM DISABILITY INSURANCE

Effective July 25, 2015, The Standard will replace Cigna as the new insurance carrier for short-term and long-term disability insurance and the new administrator for the protected leaves. If you need to file a leave request or disability insurance claim on or after July 25, 2015, you can contact The Standard at (844) 239-3560 or at [www.Standard.com](http://www.Standard.com). For a currently active/open disability insurance claim, you can continue to coordinate with your designated contact with Cigna or at (800) 238-5834.

### MEDICAL EXPENSE REIMBURSEMENT (FSA)

**Maximum Annual Contribution:** For tax year 2015, the IRS announced that the annual maximum contribution for flexible spending accounts (FSA) increased from \$2,500 to \$2,550. If an employee's MOU, Compensation Plan, Salary Ordinance, or Employment Contract allows for contributions up to the Internal Revenue Code (IRC) annual maximum, the employee may elect to contribute up to \$2,550 for plan year 2015-16, which equates to bi-weekly deductions of \$98.07.

**Rollover:** In 2014, the IRS issued a new ruling that allows employers to roll-over up to \$500 of participant funds remaining in their FSA Account at the end of each plan year. Plan participants must enroll in the next plan year to be eligible for the rollover.

Effective May 5, 2015, the County amended the FSA Plan Document to allow this option for County FSA plan participants if their MOU, Compensation Plan, Salary Ordinance, or Employment Contract allows for it.

### BENEFIT ENHANCEMENTS

**Breast Cancer Medications:** Effective July 25, 2015, certain anti-cancer medications that are prescribed by a plan provider will be available at no cost to women who are at an increased risk for breast cancer. This benefit change will be added to Blue Shield and Kaiser plans.

**Lung Cancer Screenings:** Effective July 25, 2015, computed tomography (CT) scans that are authorized by a plan provider will be provided at no cost to individuals with an increased risk for lung cancer. This benefit change will be added to Blue Shield and Kaiser plans.

### CHANGE-IN-STATUS EVENTS

**Insurance Marketplace Opt-Outs:** Effective May 5, 2015, employees whose dependents gain comparable medical coverage through a federal or state healthcare exchange may be removed from the employee's medical plan pursuant to IRC Section 125 rules. Comparable coverage is defined as a plan with outpatient medical, hospital, and prescription benefits.

For specific information, refer to the Section 125 change-in-status event matrix that begins on page 12.

### WELLNESS

The County of San Bernardino is proud to be recognized by the American Heart Association as a Gold Level Fit-Friendly Worksite. Physical activity and employee wellness are very important priorities to the County, and we encourage all of our employees to participate in the My Health Matters! wellness program.

**2014-15 Wellness Campaign Reminder:** Employees have until June 30, 2015 to redeem \$100 in rewards for participating in the 2014-15 campaign.

**2015-16 Wellness Campaign:** A new wellness campaign will be launched in September 2015.

## 2015 OPEN ENROLLMENT MASTER SCHEDULE

<b>JUNE 1</b>	Mon	<p>Open Enrollment begins! Informational meetings are scheduled throughout the County. Check the meeting schedule included in this guide for locations, dates and times.</p> <p>During Open Enrollment, if you are eligible, you may:</p> <ul style="list-style-type: none"> <li>• Enroll in a medical, dental, and/or vision plan</li> <li>• Change medical, dental, and/or vision plans</li> <li>• Add dependents to or remove them from your medical, dental, and/or vision plans</li> <li>• Opt-out of a County-sponsored medical plan and/or dental plan (other comparable group coverage required)</li> <li>• Change your refundable/non-refundable retirement contribution election (availability of option based on your SBCERA membership date, applicable MOU, and/or provisions of the Public Employees' Pension Reform Act (PEPRA))</li> <li>• Enroll in the Medical Expense Reimbursement Plan (FSA). If you choose to participate in the FSA Plan, <b>you must enroll every year</b>, even if you are currently participating</li> <li>• Enroll in Supplemental Life and/or Accidental Death and Dismemberment (AD&amp;D) insurance</li> <li>• Change your Benefit Plan Premium Conversion Option elections</li> <li>• Add/change your beneficiary information</li> </ul> <p>Should you need help with completing your online Open Enrollment, one-on-one assistance is available 7:30 a.m. to 5:00 p.m. Monday through Friday at EBSD, 157 West Fifth Street, First Floor, San Bernardino. No appointment necessary — walk-ins are welcome. Computer access is also available at this location. You can receive this service on County time with your supervisor's approval.</p>
<b>JUNE 19</b>	Fri	<b>Open Enrollment ends at midnight!</b> This is the deadline to submit your 2015 benefit elections using eBenefits.
<b>JULY 6</b>	Mon	<b>Deadline to submit proof of dependency for newly added dependents and opt-out verification for new opt-outs.</b> Failure to provide documentation will result in denial of elections.
<b>JULY 11</b>	Sat	Premium rate change effective date for paycheck deductions. 2015-16 benefit elections will be available for viewing using EMACS self-service.
<b>JULY 25</b>	Sat	Effective date of coverage for changes made to medical, dental, vision, supplemental life and AD&D plans.
<b>AUG 5</b>	Wed	Pay warrants reflect open enrollment rate changes.

## 2015-16 BI-WEEKLY PREMIUM RATE TABLE

Rates Effective July 11, 2015\*

Coverage Effective July 25, 2015

Plan	Coverage Type	2015-16 Bi-Weekly Rates	2014-15 Bi-Weekly Rates	Difference in Bi-Weekly Premium	Percentage Change from 2014-15
Kaiser	Employee Only	\$265.67	\$269.04	(\$3.37)	-1.25%
	Employee + 1	\$544.97	\$551.91	(\$6.94)	-1.26%
	Employee + 2	\$770.32	\$780.14	(\$9.82)	-1.26%
Blue Shield Signature HMO	Employee Only	\$225.26	\$218.56	\$6.70	3.07%
	Employee + 1	\$448.51	\$435.12	\$13.39	3.08%
	Employee + 2	\$633.80	\$614.86	\$18.94	3.08%
Blue Shield PPO	Employee Only	\$418.01	\$398.43	\$19.58	4.91%
	Employee + 1	\$849.81	\$809.91	\$39.90	4.93%
	Employee + 2	\$1,317.92	\$1,255.97	\$61.95	4.93%
Blue Shield PPO – Needles**	Employee Only	\$471.71	\$449.60	\$22.11	4.92%
	Employee + 1	\$958.75	\$913.71	\$45.04	4.93%
	Employee + 2	\$1,484.50	\$1,414.71	\$69.79	4.93%
Cigna Dental HMO	Employee Only	\$10.28	\$9.63	\$0.65	6.75%
	Employee + 1	\$16.64	\$15.51	\$1.13	7.29%
	Employee + 2	\$21.71	\$20.21	\$1.50	7.42%
Cigna Dental PPO	Employee Only	\$24.50	\$24.50	\$0.00	0.00%
	Employee + 1	\$45.67	\$45.67	\$0.00	0.00%
	Employee + 2	\$78.15	\$78.15	\$0.00	0.00%

\*Premium rates are pending approval by the Board of Supervisors. Premiums do not include any medical/dental premium subsidies you may be eligible for. Please refer to the Premium Subsidies section on page 11.

\*\*For employees assigned to work in the Needles, Trona and Baker work locations, the County has established a "Needles Subsidy." The Needles Subsidy is paid by the employee's Department and is equal to the amount of the premium difference between the indemnity health plan offered in these specific work locations and the lowest cost health plan provided by the County.

**Your benefits are an important part of your compensation package.**



## CONTACT INFORMATION

	Address	Phone	Web Site
<b>Board of Retirement (SBCERA)</b>	348 W. Hospitality Lane, Third Floor San Bernardino, CA 92415-0014	(909) 885-7980 (877) 722-3721	<a href="http://www.sbcera.org">www.sbcera.org</a>
<b>Employee Benefits and Services</b>	157 West Fifth Street, First Floor San Bernardino, CA 92415 Interoffice Mail Code: 0440	(909) 387-5787	<a href="http://mybenefitsatwork">http://mybenefitsatwork</a>
	AD&D / Life Insurance COBRA Combined Giving Campaign Commuter Services Dependent Care Assistance Program (DCAP) Medical Expense Reimbursement (FSA) Kaiser Permanente Long-Term Disability Medical Emergency Leave Retirement Medical Trust Salary Savings Section 125 Short-Term Disability Vision	(909) 387-5537 (909) 387-5552 (909) 387-5831 (909) 387-9640 (909) 387-5648 (909) 387-5648 (909) 387-5831 (909) 387-5787 (909) 387-5787 (909) 387-5537 (909) 387-6098 (909) 387-5555 (909) 387-5787 (909) 387-5831	<a href="http://countyline.sbcounty.gov/commuterservices/">http://countyline.sbcounty.gov/commuterservices/</a>
<b>My Health Matters! Program</b>	email: <a href="mailto:mhm@hr.sbcounty.gov">mhm@hr.sbcounty.gov</a>	(909) 387-5787	<a href="http://countyline.sbcounty.gov/hr/benefits/mywellness/home.asp">http://countyline.sbcounty.gov/hr/benefits/mywellness/home.asp</a>
Steps to Success	<a href="http://www.healthycommunity.ca/sanbernardino/hr/default.aspx">http://www.healthycommunity.ca/sanbernardino/hr/default.aspx</a>		
<b>Providers:</b>			
Blue Shield of California (HMO, PPO and Needles PPO)	P.O. Box 272540 Chico, CA 95927-2540	(800) 642-6155	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Blue Shield Mental Health Service Administration (MHSA), includes substance abuse services (HMO, PPO and Needles PPO)	Blue Shield of California MHSA P.O. Box 719002 San Diego, CA 92171-9002	(877) 263-9952	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Cigna Dental Care (DHMO)	P.O. Box 188046 Chattanooga, TN 37422-8046	(800) 238-5834	<a href="http://www.cigna.com">www.cigna.com</a>
Cigna Dental PPO	P.O. Box 188037 Chattanooga, TN 37422-8037	(800) 238-5834	<a href="http://www.cigna.com">www.cigna.com</a>
EyeMed Vision	P.O. Box 8504 Mason, OH 45040-7111	(877) 406-4146	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>
Voya Financial (formerly ING)	1030 Nevada Street, Suite 203 Redlands, CA 92374	(909) 748-6468 (800) 584-6001	<a href="http://www.voyaretirementplans.com/custom/sanbern">www.voyaretirementplans.com/ custom/sanbern</a>
Kaiser Permanente	P.O. Box 7004 Downey, CA 90242-7004 (Claims Administration)	(800) 464-4000	<a href="http://www.kp.org">www.kp.org</a>
Kaiser Permanente Mental Health Offices and Services	(866) 205-3595 Appointments (800) 900-3277 Member help line, after hours, weekends & holidays		<a href="http://www.kp.org">www.kp.org</a>
Kaiser Permanente Release of Information (for disability and protected leaves certification paperwork)	17284 Slover Ave., Palm Court II, Suite 202 Fontana, CA 92337	(909) 609-3232	
The Standard (STD/LTD, FMLA/CFRA/PDL)	Employee Benefits Department PO Box 2800 Portland, OR 97208	(844) 239-3560 (971) 321-8400 Fax	<a href="http://www.Standard.com">www.Standard.com</a>
Minnesota Life	400 Robert Street St. Paul, MN 55101 Attn: Group Administration Dept.	(866) 293-6047	<a href="http://www.minnesotalife.com">www.minnesotalife.com</a>
<b>San Bernardino County Public Employees Association (SBPEA)</b>	433 North Sierra Way San Bernardino, CA 92410	(909) 889-8377 (877) 312-3333	<a href="http://www.sbpea.com">www.sbpea.com</a>
<b>San Bernardino County Safety Employees' Benefit Association (SEBA)</b>	735 East Carnegie Drive, Suite 125 San Bernardino, CA 92408	(909) 885-6074 (800) 655-7322	<a href="http://www.seba.biz">www.seba.biz</a>

## 2015 OPEN ENROLLMENT MEETING SCHEDULE

Benefits are an important part of your total compensation package. Take advantage of this opportunity to review your benefit plan options. **Please allow up to 1½ hours per session.\***

*\* You may attend these meetings on County-paid time with supervisory approval.*

City	Date	Day	Time	Location
Colton	5/26/15	Tues	8:30 a.m. & 10:00 a.m.	ARMC - Oak Room 400 North Pepper Avenue
Fontana	6/1/15	Mon	2:00 p.m. & 3:30 p.m.	TAD - Crosswell Commons Conference Room 7977 Sierra Avenue
San Bernardino	6/9/15	Tues	8:30 a.m. & 10:30 a.m.	SBPEA 433 North Sierra Way
San Bernardino	6/9/15	Tues	1:30 p.m. & 3:00 p.m.	Hall of Records - ATC Conference Room A & B, Fourth Floor, 222 West Hospitality Lane
San Bernardino	6/11/15	Thurs	8:30 a.m. & 10:30 a.m.	County Government Center, Board Chambers 385 North Arrowhead Avenue
Hesperia	6/11/15	Thurs	2:00 p.m.	TAD - Conference Room B 9655 9th Avenue
San Bernardino	6/15/15	Mon	9:30 a.m. & 11:00 a.m.	Department of Public Works - Hearing Room 825 East Third Street
Victorville	6/15/15	Mon	1:30 p.m. & 3:00 p.m.	Victorville TAD - Oasis Room 15010 Palmdale Road
Rancho Cucamonga	6/16/15	Tues	9:00 a.m. & 11:00 a.m.	DAAS - Haven Room 9445 Fairway View Place, Ste. 110
Redlands	6/16/15	Tues	1:30 p.m. & 3:00 p.m.	TAD - Orange Grove Room 1181 Lugonia Avenue/Nevada (on corner)

### Open Enrollment meeting broadcast on CountyDirect

The June 11 meeting in San Bernardino will be broadcast on CountyDirect and archived for viewing throughout Open Enrollment. The meeting will be available year round at <http://countyline/Countydirect.asp> for your reference.

## SUMMARY OF BENEFITS AND COVERAGE

You may view Summary of Benefits and Coverage (SBC) information for the County's medical plans online at:

Intranet <http://mybenefitsatwork>

Internet [http://www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx)

## BENEFIT ELIGIBILITY

To be eligible for the benefits listed in this guide, you must be an employee in a regular position scheduled to work a minimum of 40 hours per pay period and have received pay for at least one half plus one hour of your scheduled hours (or be on an approved leave pursuant to applicable law). Safety employees must be scheduled and paid for a minimum of 41 hours a pay period.

The benefit must be offered to you through a MOU, Exempt Compensation Plan, Contract or Salary Ordinance.

### Dependent Eligibility

If you are eligible to participate in County-sponsored medical and dental plans, your eligible dependents may also participate. Your eligible dependents are:

✓ Your qualifying children

Your qualifying children include children up to age 26 that are born to you, your stepchildren, children legally adopted by you (including those children during any waiting period before the finalization of their adoption), children for whom you are the permanent legal guardian, and children you support as a result of a valid court order.

Qualifying children over the age of 26 that are supported primarily by you and incapable of self-sustaining employment by reason of total and permanent mental or physical disability are also eligible for coverage.

✓ Your qualifying relative

Qualifying relatives who are eligible for medical and dental coverage are limited to your spouse, your domestic partner's children, and your grandchildren (for Kaiser Permanente members only). Kaiser Permanente allows coverage for grandchildren if the dependent child was enrolled with Kaiser Permanente prior to the birth of the grandchild. Coverage for the grandchild may continue as long as the dependent child is covered. Other benefit plans do not allow for coverage of grandchildren. Please consult with the applicable Evidence of Coverage or contact the benefit plan directly for clarification before you submit your enrollment.

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, and relatives other than those listed above are not eligible for County-sponsored medical and dental plans.

✓ Your state registered domestic partner

The following documents may be used as proof of relationship:

✓ Qualifying Child/Relative:

- Photocopy of birth certificate (legal or hospital) or verification of birth (e.g., Kaiser hospital printout of birth) – not keepsake or handwritten
- Photocopy of a certificate of baptism (must include date of birth and show employee as parent)
- Photocopy of marriage certificate (legal or church – not keepsake or handwritten)
- Photocopy of court documents for:
  - Adoption
  - Placement
  - Custody

- Legal Guardianship
  - Other court order stating dependent status
  - Other court order stating benefit coverage must be provided
- ✓ Domestic Partner:
- Photocopy of the Certificate of State Registered Domestic Partnership or equivalent out-of-state certificate

Mail or fax required documentation to:

Employee Benefits and Services Division  
 157 West Fifth Street, First Floor  
 San Bernardino, CA 92415  
 Interoffice Mail Code: 0440  
 Fax: (909) 387-5566  
 Email: ebsd@hr.sbcounty.gov

**Be sure to write your employee ID number on the top right corner of each page you submit.**

## **ENROLLMENT**

As a condition of County employment, if you are an eligible employee, you must enroll in a County-sponsored medical and dental plan unless you have other employer-sponsored group medical and/or dental insurance. Premiums for County-sponsored medical and dental insurance will be deducted from your paycheck.

If you are an active employee, enrolled in a County-sponsored medical plan, and reach age 65, you will be given the option of remaining on the County-sponsored plan or electing coverage under Medicare Parts A and B. You will be notified of this option just prior to turning 65.

### **Benefits Calculator Available Online**

The benefits calculator is available for use on the EBSD web page, and can help you determine how much bi-weekly out-of-pocket expense you will have. You can access this calculator through the Internet at <http://www.sbcounty.gov/hr/benefitcalculator/BenefitCalculatorSearch.aspx> or through Countyline at <http://mybenefitsatwork>.

### **Opt-Out**

If you have other employer-sponsored group medical and/or dental insurance that offers coverage comparable to a County-sponsored plan, you may elect to opt-out of the County-sponsored medical and/or dental insurance.

If you are newly opting-out during this annual Open Enrollment, you must provide proof of other employer-sponsored group insurance that includes the effective date of the coverage. If you fail to provide the required documentation by **5:00 p.m., July 6, 2015**, your previous County-sponsored medical and/or dental plan coverage will be reinstated.

If you are currently opted-out of the medical and/or dental plans and have no changes to the coverage on file, no further action is needed.

New employees and employees making mid-year changes must complete the Opt-Out Election Agreement form and submit it to EBSD.

## Medical and Dental Plan ID Cards

Within a month of the effective date of your coverage, you should receive identification (ID) cards from your medical and dental plans. You may, however, begin using your medical and dental benefits before receiving your ID cards. If you do not receive your ID cards, or if you need replacement cards, please refer to plan contact information on page 5 of this guide. You can also request or print out your ID cards online at the plan website(s). If you have a problem accessing care, call EBSD at (909) 387-5787 or email [ebds@hr.sbcounty.gov](mailto:ebds@hr.sbcounty.gov).

## Internal Revenue Code Section 125 Premium Conversion Plan

### ***Purpose***

This plan allows employees to pay their share of eligible benefit plan premiums using either before-tax or after-tax dollars.

### ***Eligible Benefit Plan Premiums***

You may elect to pay for the following plan premiums before or after tax:

- ✓ Medical
- ✓ Dental
- ✓ Vision
- ✓ Accidental death & dismemberment (AD&D)
- ✓ Voluntary life insurance premiums

**NOTE:** Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) are ineligible for pre-tax deduction per IRS regulations.

### ***Before-Tax***

This option is especially attractive, as it results in greater take-home pay. It does, however, limit your mid-year changes (involving premium increases or decreases) to the change-in-status events as specified in IRC Section 125 and the County's Section 125 Premium Conversion Plan.

### ***After-Tax***

This option results in less take home pay. Changes during the plan year are still limited to those allowed by the County's contracts, agreements, or plan documents governing the benefits.

### ***Elections***

You must notify the County of your election to pay for premiums either before or after tax premiums as follows:

**Open Enrollment:** During open enrollment you have an opportunity to change your current before or after tax elections through eBenefits. If you do not wish to make changes to your current elections, they will automatically continue.

**New Hire:** New employees have an opportunity to make their initial before or after tax election within the first pay period following their hire date. Failure to make an initial election will result in an automatic enrollment into the lowest cost health and dental plans available on an after-tax basis. If you are automatically enrolled in a plan, you have sixty (60) days from your date of hire to change your election. This is considered a mid-year change-in-status event. Please see below for more information regarding mid-year changes.

**Mid-Year Change:** Plan elections are irrevocable for the plan year, unless a qualifying mid-year change-in-status event is experienced. Mid-year benefit plan changes must:

1. Be consistent with the qualifying event
2. Meet the guidelines of County contracts/agreements, plan documents and IRC Section 125
3. Be received by EBSD within 60 days of the qualifying event\*

*\*Submit your mid-year change paperwork within the 60 day time frame even if you are waiting to receive official documents (e.g., birth certificates, marriage certificates).*

To view a summary of the most common Section 125 mid-year change-in-status events, please refer to the Section 125 Change-in-Status Matrix on the following pages.

**Effective Date of Mid-Year Changes:** Elections made within 30 days of hire or a HIPAA special enrollment change-in-status event (e.g., acquisition of a dependent through birth, marriage, or adoption) will be processed retroactively. All other elections shall be effective prospectively. Elections will be effective the first pay period that follows the date the completed Premium Deduction Election form and applicable enrollment forms and supporting documentation are received by EBSD.

If you were terminated from County plan coverage while on leave, upon your return from leave and regaining eligibility for benefits, you will be automatically re-enrolled in the medical and dental plans you had prior to going on leave with employee only coverage. You will be billed for any premiums owed on an after-tax basis.

You will be responsible for re-enrolling any dependents whose coverage was terminated within 60 days of your return from leave. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the change-in-status event results in a decrease in premiums, you will receive a refund on a subsequent pay warrant for the premium overpayment. To reduce the amount of premiums owed or to avoid incurring an overpayment of premiums, you are encouraged to submit your paperwork as soon as possible.

**FOR NEWBORN CHILDREN:** Newborn children must be enrolled in County plan coverage to receive benefits under the plan. Failure to enroll your newborn in a County plan will result in your newborn not having coverage from date/time of birth forward. Please note should this occur you will be liable for any services and/or expenses incurred.

To enroll your newborn, submit completed mid-year change paperwork to EBSD or your payroll specialist within 60 days of the newborn's date of birth. Please note pursuant to IRS Regulations and the County's plan document, newborn coverage is made effective the first pay period following the newborn's date of birth. You are encouraged to submit paperwork as soon as possible to avoid incurring multiple premiums as a result of retroactive coverage. Remember to submit your mid-year change paperwork within the 60 day timeframe even if you are waiting to receive the newborn's official birth certificate.

Blue Shield Members: The newborn will be assigned under the medical group to which the mother (parent) is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

If you need assistance or have questions regarding mid-year change paperwork to enroll a newborn, please contact EBSD or your payroll specialist.

## Premium Subsidies

The County helps you pay for your medical and dental insurance by subsidizing your premiums through payments made directly to the carriers. The subsidy amounts vary and are based on your bargaining unit, family size, hire date, plan selection, and the number of hours you work. For specific amounts, refer to the appropriate MOU, Exempt Compensation Plan, Salary Ordinance, or Contract.

### Needles Subsidy Disclosure

Employees who are assigned to work locations in Needles, Trona, and Baker are eligible for the Needles Subsidy.

It is the responsibility of the employee to notify the Employee Benefits and Services Division (EBSD) if assigned to a Needles Subsidy eligible work location. Conversely, if an employee is receiving the Needles Subsidy and their work location changes to a non-eligible location, the employee must notify EBSD as soon as they are no longer assigned to a qualifying location.

To designate or change an election for the Needles Subsidy, employees must complete and submit the Premium Deduction Election Form (found on EMACS Forms at <http://cms.sbcounty.gov/emacs/Home.aspx>) to EBSD or their payroll specialist.

If it is discovered that an employee has been receiving the Needles Subsidy in error, the County will collect, through payroll deduction, any amount of subsidy the employee received but was not eligible.

For specific amounts, refer to the appropriate MOU, Exempt Compensation Plan, Salary Ordinance, or Contract at <http://countyline/hr/employeerelations/>

A summary of benefits by occupational unit can also be found on Countyline at <http://countyline/hr/benefits/mybenefitsbyunit/home.asp>





IRC SECTION 125 CHANGE-IN-STATUS EVENT MATRIX			
QUALIFYING CHANGE- IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL/ VISION	FSA	
Gain dependent <ul style="list-style-type: none"> <li>marriage</li> <li>domestic partnership</li> <li>birth/adoption/ placement for adoption</li> </ul>	Employee may enroll newly eligible dependent(s)	Employee may enroll or increase annual election amount	To enroll dependent(s) in health benefits or enroll/increase annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>marriage certificate, state registered domestic partner certificate and/or birth certificate(s) or hospital printout of birth</li> </ul>
Lose dependent <ul style="list-style-type: none"> <li>divorce or annulment</li> <li>domestic partnership termination</li> <li>death</li> </ul>	Employee must remove dependent; may enroll self and eligible dependent(s)	Employee may enroll, increase or decrease annual election	To remove or enroll self/dependent(s) in health benefits or increase/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>divorce, legal separation, annulment, or termination of domestic partnership decree</li> <li>death certificate</li> <li>marriage/birth certificate(s)</li> </ul>
Judgment, decree, or order resulting from divorce, annulment or change in legal custody that requires medical/dental coverage for your dependent child(ren)	Employee may enroll dependent(s)	Employee may increase annual election	To enroll dependent(s) in health benefits, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>judgment, decree or order</li> <li>birth certificate(s)</li> </ul>
Gain of coverage through spouse/domestic partner's employer or other change-in-status that results in eligibility under spouse/domestic partner's plan	Employee may opt-out (self) and/or remove dependent(s)	Employee may cease or decrease annual election	To remove self/dependent(s) from health benefits and cease/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>proof of spouse/domestic partner's employer-sponsored coverage that includes the effective date</li> </ul>
Dependent gain of coverage through a federal or state healthcare exchange	Employee may remove dependent(s). Note that dependents that drop County-sponsored coverage as a result of gaining federal or state healthcare exchange coverage will not be allowed to re-enroll in a County plan until the next open enrollment period.	No change is permissible	To remove dependent(s) from medical benefits, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Plan Enrollment Form</li> <li>proof of other coverage and effective date</li> </ul>
Loss of spouse's/domestic partner's employment	Employee must enroll self if coverage is lost and may enroll dependent(s)	Employee may enroll or increase annual election amount	To enroll self/dependent(s) in health coverage and enroll/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>proof of spouse's employment and benefit plan loss that includes loss of coverage effective date</li> <li>marriage/birth certificate(s)</li> </ul>



**IRC SECTION 125 CHANGE-IN-STATUS EVENT MATRIX (continued)**

QUALIFYING CHANGE- IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL/ VISION	FSA	
Change in employment status (i.e. part time to full time status)	Employee may elect to enroll self and dependent(s) if change caused employee to gain eligibility	Employee may elect to enroll and increase or decrease annual election amount	To enroll self/dependent(s) in health benefits or to enroll/increase FSA annual election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>proof of employment status change</li> <li>marriage/birth certificate(s)</li> </ul>
Dependent ceases to satisfy plan eligibility requirements (i.e. coverage disabled dependent)	Employee must remove dependent(s)	Employee may decrease election	To remove dependent(s) from health benefits or to decrease annual election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form or Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>proof of loss of eligibility (fsa only)</li> </ul>
Commencement of unpaid leave of absence	County contributions for health benefits will automatically cease and employee will be responsible for premium payments; failure to pay premiums will result in termination of coverage	Employee may cease or suspend annual election.	No paperwork required for health benefits cessation. To cease/suspend annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form</li> </ul>
Return from unpaid leave of absence	If coverage terminated, employee may enroll dependent(s)	Employee may elect to enroll or reinstate annual election	To enroll dependent(s), you must submit the following EMACS forms (within 60 days of event) <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical Expense Reimbursement (FSA) Plan Enrollment Form</li> <li>proof of spouse's/domestic partner's employment and plan benefit</li> <li>marriage/birth certificate(s)</li> </ul>
Residence change results in gain or loss of eligibility	Employee may enroll or remove dependent(s)	No change is permissible	To remove dependent(s) from health benefits, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>proof of residence change</li> <li>marriage/birth certificate(s)</li> </ul>
Self or dependent(s) becomes entitled or loses eligibility for Medicare or Medicaid	Employee may enroll or opt-out yourself or enroll or remove dependent(s)	No change is permissible	To enroll or opt-out yourself or enroll/remove dependent(s) from health benefits you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form</li> <li>Opt-Out Agreement</li> <li>proof of gain/loss of Medicare or Medicaid</li> <li>marriage/birth certificate(s)</li> </ul>

## EMACS SELF-SERVICE INSTRUCTIONS

<b>What is EMACS self-service?</b>	<p>An Internet and Intranet based system that allows you to:</p> <ul style="list-style-type: none"> <li>✓ Make changes to your benefits</li> <li>✓ View your choices immediately for accuracy</li> <li>✓ Print a confirmation statement</li> </ul> <p>EMACS self-service is available during the entire Open Enrollment period (June 1 through June 19, 2015). <b>You must submit your benefit elections by June 19, 2015.</b></p>	
<b>How to access EMACS self-service</b>	<p><b>If you need assistance accessing EMACS self-service, please contact the Help Desk at (909) 884-4884.</b></p>	<p><b>Sign on from a County Computer (Intranet) or from home (Internet)</b></p> <ol style="list-style-type: none"> <li>1) Go to the EMACS Sign-In Page, <a href="https://emacsbapp.sbcounty.gov">https://emacsbapp.sbcounty.gov</a></li> <li>2) Enter your User ID and Password : <ul style="list-style-type: none"> <li>– Enter your 5 or 6 digit Employee (EE) ID Number (e.g. B1234)</li> <li>– If your EE ID number starts with a number, replace the first number with the letter "X"</li> </ul> </li> <li>3) Click the "Sign In" button</li> </ol>
<b>To view current elections in EMACS self-service (electronic benefits statement)</b>	<p>Click on Self Service&gt;Benefits&gt;Benefits Summary.</p>	
<b>Add Dependents and/or Beneficiaries</b>	<p><b>This page allows you to add dependents and/or beneficiaries to a list you will have available to select from once you are ready to make your medical, dental, and insurance elections.</b></p> <p><b>Please note:</b> This screen does not enroll dependents in applicable benefit plans. If you are enrolling, dis-enrolling, or changing status, please proceed to the "Enrollment Process" section of these instructions.</p> <p><b>Click on Self Service&gt;Benefits&gt;Dependent/Beneficiary Summary</b></p> <ul style="list-style-type: none"> <li>✓ Review the listing of dependents and/or beneficiaries you have to choose from.</li> </ul> <p><b>Edit information on an existing dependent and/or beneficiary</b></p> <ul style="list-style-type: none"> <li>✓ Click on the name and then "Edit"</li> <li>✓ Edit information as necessary then click "Save"</li> <li>✓ Click "OK"</li> <li>✓ Click to go back to the <i>Dependent/Beneficiary Summary</i> page</li> </ul> <p><b>To add a dependent who is not listed</b></p> <ul style="list-style-type: none"> <li>✓ Click on "Add a dependent or beneficiary" and enter the required information.</li> <li>✓ Click "Save" and then click "OK".</li> <li>✓ Click "Return to Dependent/Beneficiary Summary" to go back to the summary page</li> </ul> <p><b>For dependents who are disabled</b>, you must complete the Disabled Dependent Certification.</p>	
<b>Enrollment Process</b>	<p><b>Starts the enrollment process and allows you to view and make changes to your current plans.</b></p> <ul style="list-style-type: none"> <li>✓ Click on Self-Service&gt;Benefits&gt;Benefits Enrollment</li> </ul> <p><b>Benefits Enrollment page</b></p> <ul style="list-style-type: none"> <li>✓ Click "Info" icon  for general information</li> <li>✓ Click "Select" to begin the enrollment process</li> <li>✓ Review the information provided on the Section 125 Premium Conversion Plan, which explains tax options</li> <li>✓ Click "OK"</li> </ul> <p><b>Enrollment Summary Page</b></p> <ul style="list-style-type: none"> <li>✓ Review your current benefit elections (scroll down the page to view all benefits)</li> <li>✓ Click "Edit" to view and make changes as necessary</li> </ul>	

## EMACS SELF-SERVICE INSTRUCTIONS *(continued)*

	MEDICAL	DENTAL	OPT-OUT / WAIVE
<b>What you need to know/do</b>	View plan choices, premiums, and make changes	View plan choices, premiums, and make changes	Decline participation in County medical and/or dental plans if you have coverage under another group plan
<b>To enroll</b>	Click the button next to the plan name. To enroll dependents, check the <b>"Enroll"</b> box next to each dependent's name	Click the button next to the plan name. To enroll dependents, check the <b>"Enroll"</b> box next to each dependent's name	Click the <b>"Edit"</b> button next to the plan name
<b>Additional steps</b>	<p>Blue Shield HMO <b>NEW enrollees only:</b></p> <p>Select a Primary Care Physician and Medical Group for yourself and your dependent(s) in eBenefits by clicking the <b>"Select a Provider"</b> link to enter Blue Shield's website, or by calling Blue Shield Member Services at (800) 642-6155.</p> <p>Use the <b>"Find a Provider"</b> tool on Blue Shield's website to find your physician in the network. Click on the physician's name to locate the provider number and the medical group/IPA number.</p> <p>In eBenefits, enter the 9-digit provider number and the 9-digit medical group/IPA number.</p> <p>If your physician is different for any listed dependents, you will need to provide the physician number and medical group/IPA number for each dependent enrolled in coverage.</p> <p>If you are an existing patient for the Physician number provided, be sure to check the box indicating that you have previously seen this provider.</p> <p>For <b>EXISTING</b> Blue Shield members, if you need to change your Primary Care Physician and Medical Group, please contact Blue Shield directly by calling Blue Shield Member Services at (800) 642-6155.</p>	<p>Cigna Dental Care DHMO enrollees only:</p> <p>Select a network dentist for yourself and/or your dependent(s) by either calling Cigna's Customer Service line at (800) 238-5834 or click <b>"Select a Provider"</b> to enter Cigna's website</p> <p>To locate a provider on Cigna's website, click on <b>"Find a Doctor"</b> at the top of the page. Choose the <b>"Dentist"</b> radio button and enter your search criteria (provider name, location, etc.). Select the <b>"Cigna Dental Care (HMO)"</b> radio button and then select <b>"Dental Care Network"</b> and a <b>"Dentist Type"</b> (optional) in the drop down boxes.</p> <p>In eBenefits, enter the 6-digit dentist provider number. Omit any dashes or spaces when entering the number.</p> <p>If your Dentist is different than any of your listed dependents, you will need to provide a Dentist number for each dependent enrolled in coverage.</p> <p>If you are an existing patient of the Dentist number provided, be sure to check the box indicating that you have previously seen this provider.</p>	<p>From among the plan choices, click the <b>"Waive/Opt-Out"</b> button. Select the appropriate "Waive Reason" from the box.</p> <p>If your coverage is provided by a non-County group, select <b>"Opt-Out"</b></p> <p>Complete the Opt-Out Election Agreement section with your other insurance information</p> <p>Select <b>"Covered by other County Employee"</b> if this is the source of your other coverage</p> <p>Enter the employee ID of your spouse/domestic partner</p> <p>Please note: You will be required to provide substantiating documentation for opt-out/waive. Please see the opt-out section of this guide on page 8 for details and deadlines.</p>
<b>Store</b>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>
<b>Save</b>	On the Enrollment Summary page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.	On the Enrollment Summary page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.	On the Enrollment Summary page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.
<b>Note</b>	<p>If you are a new enrollee, and you do not select a provider or medical group, Blue Shield will assign one to you.</p> <p>You will be able to change your provider by calling Blue Shield Member Services directly at (800) 642-6155.</p>	<p>If you do not select a dentist, Cigna will assign one to you.</p> <p>You will be able to change your dentist by calling Cigna Customer Service directly at (800) 238-5834.</p>	For new opt-out/waive elections, you <b>MUST</b> provide verification of the other group-sponsored health/dental coverage to EBSD by July 6, 2015.

## EMACS SELF-SERVICE INSTRUCTIONS *(continued)*

	VISION	FSA	RETIREMENT OPTIONS <i>(This option is only applicable and available to certain bargaining units and Tier groups)</i>
<b>What you need to know/do</b>	Select dependent coverage (applies to certain bargaining units)	Enrollment is voluntary, but you must enroll every year to continue participating	Decide between refundable and non-refundable options
<b>To enroll</b>	Employee-only enrollment is automatic	Click the button next to <b>"Yes, I elect to enroll"</b>	Select between refundable and non-refundable options
<b>Additional steps</b>	To add dependents, check the <b>"Enroll"</b> box next to each dependent's name	Enter your election for 2015-16 in the <b>"Annual Pledge"</b> box Click <b>"Worksheet"</b> to calculate your per-pay-period contributions Click <b>"Return"</b> to go back to the <i>Flexible Spending Account</i> page	To select a different option, click the button to the left of your <b>"Plan Name"</b>
<b>Store</b>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>
<b>Save</b>	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections on page 17 for more information.



## EMACS SELF-SERVICE INSTRUCTIONS *(continued)*

	BASIC LIFE	AD&D	SUPPLEMENTAL LIFE
<b>What you need to know/do</b>	100% County paid	Review coverage levels, premiums and tax options	Review coverage levels and tax options
<b>To enroll</b>	Enrollment is automatic	Enrollment is voluntary	Enrollment is voluntary
<b>Additional steps</b>	Make desired beneficiary and allocation changes	Click the button next to the level of desired coverage or click <b>"Waive"</b> to terminate coverage Make the desired beneficiary and allocation changes	Enter a coverage amount to indicate your desired level of coverage or click <b>"Waive"</b> to terminate coverage Make the desired beneficiary and allocation changes
<b>Store</b>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>	Click <b>"Store"</b> to hold your choices. Click <b>"OK"</b> to return to <i>Enrollment Summary</i>
<b>Save</b>	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections below for more information.	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections below for more information.	On the <i>Enrollment Summary</i> page, click <b>"Submit"</b> to finalize and submit your elections. See Finalize and SUBMIT Open Enrollment Elections below for more information.

<b>Finalize and SUBMIT Open Enrollment Elections</b>	<ul style="list-style-type: none"> <li>✓ Review your benefit elections on the Enrollment Summary page. Estimates of the bi-weekly premiums for new elections are displayed at the bottom of this page</li> <li>✓ Click "Submit" after reviewing your benefit elections to access the <i>Submit Benefit Choices</i> page</li> <li>✓ Read the terms and conditions. Click "Submit" to finalize your benefit elections, which constitutes your signature</li> <li>✓ Print the <i>Submit Confirmation</i> page and retain it for future reference. Confirmation of your Open Enrollment elections will be available through EMACS self-service on July 11, 2015. You can access them by logging in to EMACS. Once logged in click Self-Service&gt;Benefits&gt;Benefits Summary</li> <li>✓ Click "OK" on the <i>Submit Confirmation</i> page to return to the <i>Benefits Enrollment</i> page</li> <li>✓ Click "Sign Out" in the upper right hand corner of the page to exit eBenefits</li> </ul> <p><b>NOTE:</b> You may review or change your benefit elections in eBenefits until the Open Enrollment deadline at midnight June 19, 2015</p>
<b>Need Further Assistance?</b>	<ul style="list-style-type: none"> <li>✓ Contact the Help Desk at (909) 884-4884 for technical assistance. Your call will be logged and a representative will contact you. Calls received after 5:00 p.m. or on weekends will be returned the next business day.</li> <li>✓ Contact EBSD at (909) 387-5787 or ebsd@hr.sbcounty.gov</li> </ul>

## BLUE SHIELD SIGNATURE HMO

This is a general summary of Blue Shield Signature HMO benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the plan documents and Evidence of Coverage (EOC). If there are any discrepancies between the information contained in this summary and the provisions of the plan documents, the provisions of the plan documents will prevail.

Blue Shield Signature HMO is a Health Maintenance Organization (HMO) plan with a Point-of-Service (POS) provision. The HMO provision requires that you select a Primary Care Physician (PCP) from one of the Blue Shield Participating Physician Groups. The POS component gives you the option of seeking consultations and evaluations from any specialist within the Blue Shield Preferred Provider Organization (PPO) network without a referral from your PCP. The HMO provision is referred to as Level 1 and the POS provision as Level 2.

Under Level 1 (the HMO), you receive all of your care from within your PCP's network of participating physicians, hospitals, and other health care providers. Under Level 2 (the POS option), you are allowed consultations with a doctor outside of your Participating Physician Group, but within Blue Shield's PPO network, without a referral from your PCP.

### How the Plan Works

When you enroll in the Shield Signature HMO plan, you will need to choose a Personal Physician (primary care physician) for you and your enrolled dependents from the list of Personal Physicians in the Blue Shield HMO physician network.

You have the option to choose a different Personal Physician and medical group for yourself and each enrolled family member. If you choose a Personal Physician you have already seen, please let Blue Shield know that you are an existing patient. When enrolling in the Shield Signature plan, you will need your Personal Physician's Blue Shield provider number and medical group/IPA number, which can be found by searching for the physician by name in the *Find a Provider* section of [www.blueshieldca.com](http://www.blueshieldca.com).

Signature Level 1 is your "HMO level" of benefits. Using your Signature Level 1 benefits provides you with the highest level of benefits – i.e., full plan benefits at the lowest out-of-pocket cost to you. However, you will only be covered under the Signature Level 1 when care is provided by your Personal Physician or any provider authorized by your Personal Physician. There is an exception: Under the Signature Level 1 benefits, women are allowed to self-refer for one annual OB/GYN appointment when they select an OB/GYN who is in the same medical group/IPA as their Personal Physician.

Using your Shield Signature Level 1 (HMO) benefits through your Personal Physician is the most cost-effective way to use your Shield Signature plan, for the lowest out-of-pocket-costs.

Signature Level 2 is your "PPO level" of benefits. Under your Signature Level 2 benefits you can see any doctor or specialist in the Blue Shield PPO network without a referral from your Personal Physician for selected outpatient services. When you use this option, your share of costs will be higher than with Signature Level 1. Please note that while this additional PPO outpatient benefit enhances your range of covered services and gives you more choices, you will be responsible for applicable copayments, and non-covered charges, and you are still required to receive all inpatient care from a hospital or other inpatient facility, participating hospice agencies, and non-physician health care practitioners under your Signature Level 1 HMO coverage.

This direct access PPO feature for selected outpatient services only covers office visits, consultation, evaluation, and treatment – limited to procedures that can be performed in the doctor's office. To find a Level 2 Provider, go to [www.blueshieldca.com/findaprovider](http://www.blueshieldca.com/findaprovider). Choose "Select a plan," under "Medical Plan," choose Blue Shield of California PPO Network, then click "Set plan" and select the type of provider that you are searching for.

Please note that services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your designated Personal Physician under your Shield Signature Level 1 benefits.

If you need a Blue Shield HMO or PPO Provider Directory, please call Blue Shield's Customer Service at (800) 642-6155 or visit Blue Shield's web site at [www.blueshieldca.com](http://www.blueshieldca.com). The directory lists physicians and medical groups accepting new patients. If your current physician or medical group accepts Blue Shield but is not listed in the Directory, call Blue Shield's Customer Service for assistance. Once enrolled in Blue Shield, you can also call Customer Service to change your PCP.

### **Copayment**

For most routine HMO care, you pay a \$10 copayment. For other services, copayments range from \$10 to 50% of actual charges. For Level 2, copayments for covered benefits are normally \$30.

### **Deductible**

Under Blue Shield Signature HMO, you pay no deductibles.

### **Hospitalization**

You are covered for all medically necessary hospitalization when admitted by your PCP.

### **Emergency Care**

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. Members should go to the closest Plan Hospital for Emergency Services whenever possible.

If you obtain Emergency Services, you should notify your PCP within 24 hours after care is received unless it was not reasonably possible to communicate with the PCP within this time limit. In such case, notice should be given as soon as possible.

An emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the Member's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.



## Out-of-Area Care

**Outside of California:** The Blue Shield Signature HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement.

**NOTE:** *Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.*

Out-of-Area Follow-up Care is covered and services may be received through the BlueCard Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the PCP.

**Within California:** If you need urgent medical care but are outside of your PCP Service Area, if possible you should call Blue Shield Member Services. You may also locate a Plan Provider by visiting our web site at [www.blueshieldca.com/findaprovider](http://www.blueshieldca.com/findaprovider). However, you are not required to use a Blue Shield of California Plan Provider to receive Urgent Services. You may use any provider.

**NOTE:** *Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.*

Follow-up care is also covered through a Blue Shield of California Plan Provider and may also be received from any provider. However, when outside your PCP Service Area, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield HMO may direct the patient to receive the additional follow-up services from the PCP.

If services are not received from a Blue Shield of California Plan Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield HMO. Claims for Urgent Services obtained outside of your PCP Service Area within California will be reviewed retrospectively for coverage. When you receive covered Urgent Services outside your PCP Service Area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated based upon Blue Shield's Allowed Charges.

**BlueCard Program:** Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers.

Please obtain full details on the Blue Card Program from the current Blue Shield EOC or by calling Blue Shield's Customer Service at (800) 642-6155.



## Claim Forms

Under the Blue Shield Signature HMO (Level 1) component you do not have to file claim forms.

## Medical Transition of Care Benefit

As a new member, you are entitled to a medical review that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider.

Some examples of circumstances for you or a family member are:

- ✓ You are in the second or third trimester of pregnancy or a high-risk pregnancy and are currently established with an Obstetrician.
- ✓ You are scheduled for surgery within 3 weeks after your effective date of coverage.
- ✓ You have documented follow-up care for surgery that was completed within 6 weeks prior to your effective date of coverage.
- ✓ You have complications resulting from surgery performed within the month prior to your effective date of coverage.
- ✓ You are presently undergoing a course of chemotherapy or radiation therapy.
- ✓ You are approved for or on a waiting list for a transplant.
- ✓ You have an acute or serious chronic condition.
- ✓ You are currently receiving outpatient mental health treatment or you are currently in a chemical dependency treatment program.

If you have a transition of care issue, please contact Blue Shield's Customer Service at (800) 642-6155 and ask for assistance with transition of care. Blue Shield will assign you a case manager to guide and assist you with your specific transition of care needs.

## How to Enroll

New employees must enroll within 60 days of hire into an eligible position. Proof of dependent status is required for each dependent you enroll on the plan. Please refer to the Eligibility, Enrollment and Mid-Year Changes sections of this guide for specific details.

## What's Covered

While covered under Blue Shield, you can take advantage of comprehensive medical benefits. Please refer to the Medical Plans Comparison Chart of this guide for a summary of covered expenses. Remember, this guide only provides a summary of the benefits available through Blue Shield. The Blue Shield contract and EOC determines the exact terms, conditions, and applicable coverage exclusions.

## How to Get in Touch with Blue Shield

Call Blue Shield's Customer Service at (800) 642-6155 any time between 7:00 a.m. and 7:00 p.m. Monday – Friday or visit Blue Shield's web site at [www.blueshieldca.com](http://www.blueshieldca.com) for more information.

## BLUE SHIELD PPO & BLUE SHIELD NEEDLES PPO

Both the Blue Shield PPO and Blue Shield Needles PPO are preferred provider organizations (PPO). A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care.

### How the Plan Works

With Blue Shield PPO and Blue Shield Needles PPO, you may obtain care from an in-network or out-of-network provider. It's your choice. However, when you receive your medical care from in-network, or "PPO providers," the plan pays 80% of most covered expenses. Some covered expenses are paid only after you have paid the deductible. If you use out-of-network providers, benefits will be 70% of Usual, Customary, and Reasonable (UCR) services for the area. You will pay 30% of UCR and all charges above UCR. With out-of-network providers, the plan cannot guarantee that your chosen provider will charge fees common to the area, so your out-of-pocket costs could exceed 30%.

### Deductibles

You pay a calendar year deductible before the plan pays for certain services obtained from an in-network ("participating") or out-of-network ("nonparticipating") provider as follows:

- ✓ Shield PPO – \$250 per member, \$500 per family
- ✓ Shield Needles PPO – \$250 per member, \$500 per two-party, \$750 per family

### Emergency Care

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. Members should go to the closest Plan Hospital for Emergency Services whenever possible. Emergency Room visits not resulting in admission have a charge for services of \$50. When the member is admitted directly from the Emergency Room there are no charges for services. For more details please refer to your EOC or contact Blue Shield's Customer Service at (800) 642-6155.

### BlueCard Program

When temporarily traveling outside California or the United States, if possible, call the 24-hour toll-free number (800) 810-BLUE (2583) to obtain complete details and information on the Blue Card Program. When traveling Outside the United States, Urgent Services are available through the BlueCard Worldwide Network, but may be received from any provider.

Before traveling abroad, you can obtain the most current listing of participating providers by calling your local Member Services office or by visiting [www.bcbs.com](http://www.bcbs.com) and selecting the "Find a Doctor or Hospital" tab. Although you are encouraged to access Urgent Services through the BlueCard Worldwide Network while outside of the United States, it is not required. However, a Member is not required to receive Urgent Services outside of the United States from the BlueCard Worldwide Network.

For additional information, please refer to your EOC under 'Blue Card Program' in the How to Use Your Health Plan section or call your dedicated Blue Shield member services at (800) 642-6155.

## How to Enroll

New employees must complete a County Medical Plan Enrollment/Change form within the first 60 days of hire into an eligible position, and return it to their payroll specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

Call Blue Shield Member Services if you:

- ✓ Have a benefits question
- ✓ Need hospital precertification
- ✓ Need a provider directory
- ✓ Need a member identification (ID) card
- ✓ Have an eligibility question
- ✓ Have a claim question

## What's Covered

While covered under the PPO, you can take advantage of comprehensive medical benefits. The plan pays benefits for covered expenses you incur while enrolled in the plan, subject to the maximum benefit amounts. Please refer to the Medical Plans Comparison Chart in this guide for key covered expenses. Remember, this guide only provides a summary of the benefits available through Blue Shield. The Blue Shield contract and EOC determines the exact terms, conditions, and applicable coverage exclusions.

## How to Get in Touch with Blue Shield PPO or Blue Shield Needles PPO

Call Blue Shield's Customer Service at (800) 642-6155 any time between 7:00 a.m. and 7:00 p.m. Monday – Friday or visit Blue Shield's web site at [www.blueshieldca.com](http://www.blueshieldca.com) for more information.



## **KAISER PERMANENTE**

The Kaiser Permanente Health Maintenance Organization (HMO) is available only to employees and their eligible dependents living within the Kaiser Permanente service areas of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura Counties. Certain outlying ZIP codes within the County are not eligible for coverage through Kaiser Permanente. Please contact Kaiser Permanente's Member Services at (800) 464-4000 if you wish to verify that you are in an eligible service area.

### **How the Plan Works**

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente facilities around the country. You have access to virtually full-service, unlimited medical care at little or no cost. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will not be eligible to receive benefits, except in a life-threatening situation such as an out-of-area urgent or emergency situation.

### ***Copayments***

For most routine care, you pay a \$10 copay. For other services, copayments may range from \$5 to \$50.

### ***Deductible***

Under Kaiser Permanente, you pay no deductible and your out-of-pocket annual expenses are limited to \$1,500 per person or \$3,000 per family.

### ***Hospitalization***

Kaiser Permanente will coordinate all non-emergency admissions.

### ***Emergency Care***

If you think you have an emergency medical condition and cannot safely go to a Kaiser Permanente hospital, call 911 or go to the nearest hospital. Please see your Evidence of Coverage (EOC) for more details on your coverage and benefits.

### ***Out-of-Area Care***

If you need medical care and cannot get to a Kaiser Permanente facility, call the 800 number on the back of your ID card for guidance.

### ***Claim Forms***

Under Kaiser Permanente, you do not have to file claim forms except for out-of-area urgent or emergency care.

### **How to Enroll**

New employees must enroll within 60 days of hire into an eligible position. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

### **Kaiser Permanente Online Services ([www.kp.org](http://www.kp.org)):**

Kaiser Permanente members have on-line access to:

- ✓ Email their doctor's office or pharmacy

- ✓ Schedule, view and cancel appointments; order prescription refills
- ✓ Request a member identification (ID) card
- ✓ Use valuable online health calculators, information, discounted services and resources
- ✓ File a grievance

With a single click, members can check immunization records, details of past office visits, vital signs, certain test results, and diagnosed health conditions. This access to on-line services makes it easier for members to stay connected with their health.

## Helpful Information for New Members

If you make the decision to enroll in a Kaiser plan, please know that there is a **New Member Entry Department** that can help you:

- ✓ Find a Kaiser Permanente facility near you
- ✓ Choose your new doctor
- ✓ Transfer your prescriptions
- ✓ Schedule your first visit, and when possible “*Fast Track*” appointments with Specialists
- ✓ Learn about programs and resources to keep you healthy

Contact the New Member Entry Department, toll free, Monday through Friday from 7:00 a.m. to 7:00 p.m. at (888) 956-1616.

## Transition of Care

If you are receiving care for a serious health issue, such as an acute condition, pending surgery or advanced pregnancy, you may be eligible for Kaiser’s **Continuity of Care** program. This program can allow you to continue getting care from your current doctor or hospital. New members must meet certain criteria to qualify for Continuity of Care. As a new member, to apply for Continuity of Care, call (800) 464-4000, weekdays from 7:00 a.m. to 7:00 p.m. and weekends from 7:00 a.m. to 3:00 p.m.

## What’s Covered

While covered under Kaiser Permanente, you can take advantage of comprehensive medical benefits. Please refer to the Medical Plans Comparison Chart of this guide for a summary of covered expenses. Remember, this guide only provides a summary of the benefits available through Kaiser Permanente. The Kaiser Permanente contract and EOC determines the exact terms, conditions, and applicable coverage exclusions.

## How to Get in Touch with Kaiser Permanente

Kaiser Permanente Member Services is available twenty four hours, seven days a week, except holidays at (800) 464-4000. You can also access their website at [www.kp.org](http://www.kp.org) for more information. To obtain assistance with disability and protected leaves paperwork, contact Kaiser’s Release of Information Department in Fontana at (909) 609-3232.

## MEDICAL PLAN COMPARISON CHART

	Kaiser	Blue Shield Signature HMO	
		Level One	Level Two
Providers, Deductibles, Maximums, Preexisting Conditions			
Choice of physician and other providers	Kaiser physicians and facilities only	Shield Signature HMO Network (includes Blue Card Program access)	Shield Signature Level II Network (includes providers in Shield PPO Network)
Calendar year Deductible combined PPO/OON	None	None	
Hospital or Ambulatory Surgical Center deductible	None	None	
Lifetime benefits maximum	None	None	
Out-of-Pocket annual maximum	\$1,500 each member \$3,000 family maximum	\$1,500 each member \$3,000 family maximum	Not applicable
Preexisting condition	Fully covered	Fully covered	
Office/Outpatient Care			
Office visits	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Periodic health exams / annual physicals	No charge	No charge	You pay a \$30 copay
Hearing screenings	No charge	No charge	You pay a \$30 copay
Immunizations	No charge	No charge	You pay a \$30 copay
Family planning Infertility services	You pay 50% excludes GIFT, ZIFT and IVF	You pay 50% excludes GIFT, ZIFT and IVF	Covered under Level 1 Benefit
Tubal ligation	No charge	No charge	Covered under Level 1 Benefit
Vasectomy	You pay a \$10 copay	You pay a \$10 copay	Covered under Level 1 Benefit
Specialists	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Well baby/Well child care	No charge	No charge	You pay a \$30 copay
Well woman exam (annual)	No charge	No charge	You pay a \$30 copay
Emergency Medical Care			
Ambulance	No charge when medically necessary	No charge	No charge if medically necessary
Emergency room	You pay a \$50 copay (waived if admitted)	You pay a \$50 copay (waived if admitted)	Covered under Level 1 Benefit
Urgent care	You pay a \$10 copay	You pay a \$10 copay	

**Please note:** This comparison chart only highlights benefits. The Evidence of Coverage (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this Comparison Chart and the official plan documents, the official plan documents will prevail.

Blue Shield PPO		
	In-Network	Out-of-Network
	Shield PPO Network (includes Blue Card Program access)	Out-of-Network
	\$250 per individual \$500 per family	
	None	
	None	
	\$1,500 each member \$3,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	\$2,000 each member \$4,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)
	Fully covered	
	You pay \$10 copay [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	Not covered	Not covered
	No charge [CY ded. waived]	You pay 50% after CY deductible (A facility charge may also apply)
	You pay 30% after deductible	You pay 50% after deductible
	You pay \$10 copay [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 20% after CY deductible
	\$50 per visit + 20% after CY deductible (\$50 waived if admitted)  ER Physician Services: You pay 20% after CY deductible	\$50 per visit + 20% after CY deductible (\$50 waived if admitted & treated as in-network benefit)  ER Physician Services: You pay 20% after CY deductible
	You pay a \$10 copay [CY ded. waived]	You pay 30% after CY deductible

	Kaiser		Blue Shield Signature HMO	
			Level One	Level Two
<b>Diagnostic Services</b>				
Laboratory and Pathology Tests	No charge		No charge	Covered only when performed in physician's office
Diagnostic Tests and X-Ray	No charge		No charge	Covered only when performed in physician's office  For CT, MRI, MUGA, PET, and SPECT covered under Level 1 benefit
<b>Diabetes Care</b>				
Covered Diabetic drugs and testing supplies	See 'Prescription Drugs' Testing supplies no charge under formulary		See 'Prescription Drugs'	
Diabetes Self Management Training & Education	No charge		No charge	You pay a \$30 copay
Devices, Equipment, and Non-Testing Supplies	See Durable Medical Equipment		No charge	Covered under Level 1 Benefit
<b>Maternity Care</b>				
Prenatal and Postnatal office visits	No charge		No charge	Covered under Level 1 Benefit
Delivery	No charge		No charge	Covered under Level 1 Benefit
Newborn Care	Newborn covered 31 days; must enroll through the County within 60 days of birth		Newborn covered 30 days; must enroll through the County within 60 days of birth	Covered under Level 1 Benefit
<b>Hospital Services</b>				
Hospital care (Physician and Facility charges)	No charge for approved services obtained in a Kaiser Permanente or other approved facility		No charge	Covered under Level 1 Benefit
<b>Surgical Services</b>				
Hospital - In Patient Surgical Services	No charge (Facility and Physician services)		No charge (Facility and Physician services)	Covered under Level 1 Benefit
Outpatient/Ambulatory Surgery Center	Physician Services – No charge Facility – \$10 copay		No charge (Facility and Physician services)	Covered under Level 1 Benefit
<b>Alternatives to Hospital Care</b>				
Home health services	No charge when medically necessary; up to 100 visits per calendar year		No charge	Covered under Level 1 Benefit
Hospice Inpatient & outpatient	No charge when selected as alternative to traditional services covered by Kaiser Permanente		No charge	Covered under Level 1 Benefit
Skilled nursing facilities	No charge for authorized stays; maximum 100 days per benefit period in a plan skilled nursing facility		No charge	Covered under Level 1 Benefit



Blue Shield PPO		
	In-Network	Out-of-Network
	You pay 20% after CY deductible	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 30% after CY deductible
	See 'Prescription Drugs'	
	You pay 20% after CY deductible	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 30% after CY deductible
	Newborn covered 30 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days
	You pay 20% after CY deductible	You pay 30% after CY deductible
	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
	You pay 20% after CY deductible	If preauthorized you pay 20% after deductible (100 visits per calendar year combined PPO/OoN maximum)
	You pay 20% after CY deductible	If preauthorized you pay 20% after CY deductible
	You pay 20% after CY deductible	Freestanding: SNF if preauthorized You pay 20% after deductible 30% for OON skilled nursing unit of a hospital (100 visits per calendar year combined PPO/OoN maximum)

	Kaiser	Blue Shield Signature HMO	
		Level One	Level Two
<b>Mental Health Care and Substance Abuse Treatment</b>			
		<b>MHSA Participating Provider</b>	
Non-severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group	Inpatient: No charge Outpatient: 1-3 visits – no charge \$10 per visit thereafter	Inpatient: Not covered Outpatient: 1-3 visits – no charge \$30 per visit thereafter
Severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group (Severe Mental Disorder defined in EOC)	Inpatient: No charge  Outpatient: 1-3 visits – no charge \$10 per visit thereafter	Covered under Level 1 Benefit
Substance abuse	Inpatient: No Charge Outpatient: \$10 copay individual, \$5 copay group	Inpatient: Inpatient Hospitalization Copay Applies  Professional (Physician) Services- Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter  Professional (Physician) Services - Inpatient: No charge  Partial Hospitalization/Day Treatment: No charge	Covered under Level 1 Benefit
<b>Prescription Drugs</b>			
Prescription drugs (per fill)  Includes Diabetic drugs and testing supplies	Pharmacy (up to 100 day supply): generic - \$10 copay; brand \$15 copay; drugs prescribed for the treatment of sexual dysfunction disorders and infertility: 50% Coinsurance  Mail Order is voluntary	Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary  Specialty Pharmacies: \$10 per prescription (up to a 30-day supply)  Mail Order is voluntary 90-day supply at discounted rate	N/A
<b>Other Services</b>			
Allergy testing	You pay a \$10 copay (serum covered)	You pay a \$10 copay	You pay a \$30 copay
Chiropractic care	Not covered	Not covered	
Durable medical equipment	No charge	No charge	Covered under Level 1 Benefit
Home visits (Physician)	No charge; only when medically necessary	You pay a \$10 copay	Covered under Level 1 Benefit

Blue Shield PPO		
	In-Network	Out-of-Network
	<b>MHSA Participating Provider</b>	<b>MHSA Non-Participating Provider</b>
	Inpatient: You pay \$10 Outpatient: 1-3 visits – no charge 20% per visit thereafter (Not subject to the Calendar-Year Deductible)	Inpatient: 30% Outpatient: 30% per visit
	<b>MHSA Participating Provider</b>	<b>MHSA Non-Participating Provider</b>
	Inpatient: Inpatient Hospitalization Copay Applies  Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter (not subject to the CY deductible)  Professional (Physician) Services - Inpatient: 20% after CY deductible	Inpatient: Inpatient Hospitalization Copay Applies  Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 30% per visit  Professional (Physician) Services - Inpatient: 30%
	PARTICIPATING PHARMACY Pharmacy: \$15 generic formulary \$30 brand formulary \$30 non-formulary  Specialty Pharmacies: \$15 per prescription (up to a 30-day supply)  Mail Order is voluntary 90 day supply at discounted rate	NON-PARTICIPATING PHARMACY (Member pays 25% of billed amount plus copayment) Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary  Specialty Pharmacies: Not covered  Mail Order not covered
	Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum.	
	Office Visit: You pay 20% (CY ded. waived)  Allergy Injection Services (serum not included) \$15 visit (CY ded. waived)	Office Visit: You pay 30%  Allergy Injection Services (serum not included) \$15 visit (CY ded. waived)
	You pay 20% after CY deductible	You pay 30% after CY deductible
	Up to 30 visits per calendar year combined PPO/OoN maximum	
	You pay 20% after CY deductible	You pay 30% after CY deductible
	You pay 20% (CY ded. waived)	You pay 30% after CY deductible

	Kaiser	Blue Shield Signature HMO	
		Level One	Level Two
Other Services (continued)			
Physical and Occupational Therapy	You pay a \$10 copay	Office: You pay a \$10 copay	Office: You pay a \$30 copay (up to 12 combined visits per calendar year)  Facility copay (if applicable) not covered on Level II
Speech Therapy	You pay a \$10 copay	You pay a \$10 copay	Office: You pay a \$30 copay  Facility copay not covered on Level II
Vision (exam only)	No charge	You pay a \$10 copay	
Travel			
Network	Kaiser facilities in the US Claim forms required for Out of Area Urgent and ER care	Inside of US: Blue Card Program Outside of US: Blue Card World Wide Refer to your EOC	N/A
Immunizations for purposes of Foreign Travel	No charge	\$10 per injection	\$30 per injection
Additional Travel Information	kp.org (search for “Travel Health”)	blueshieldca.com	N/A

### **IMPORTANT NOTICE FROM THE COUNTY OF SAN BERNARDINO ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

#### **Certificate of Creditable Medicare Prescription Drug Coverage**

The County of San Bernardino hereby certifies that the prescription drug coverage it provides to Medicare-eligibles is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay. It is therefore designated as providing "creditable coverage," meaning that any participant who later enrolls in a Part D plan will not be charged a late-enrollment penalty.

If you have any questions about this notice, please call the County's Human Resources Department, EBSD at (909) 387-5787, or request a copy in writing from the County of San Bernardino, Human Resources Department, EBSD, 157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440. You will be informed should any County plan lose its creditable coverage status.

Notes:

## **CIGNA DENTAL CARE**

This is a general summary of Cigna Dental DHMO and DPPO plan benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the Evidence of Coverage (EOC). If there are any discrepancies between the information contained in this summary and the provisions of the EOC, the plan document will prevail. EOCs can be obtained online at [http://www.sbcounty.gov/hr/cd\\_plan.aspx](http://www.sbcounty.gov/hr/cd_plan.aspx)

Additionally, an overview of the most highly utilized plan benefits and their applicable copayments can be found in the dental comparison chart within this guide. For a complete listing of plan benefits, please refer to the plan's EOC.

Cigna Dental provides its members access to a full service website that allows you to access, view and print valuable information pertaining to your benefits and treatment. Information available includes benefit details, DPPO claim status, provider search capabilities and printable ID cards.

## **CIGNA DENTAL CARE (DHMO)**

Cigna Dental Care is a prepaid "HMO-style" dental plan that contracts with more than 4,500 dental offices and 3,100 unique dentists across southern California.

Cigna Dental Care (DHMO) Features:

- ✓ No claim forms
- ✓ No deductibles
- ✓ No annual maximum benefit
- ✓ Preexisting conditions are not excluded, except for work in progress
- ✓ Out-of-pocket savings are substantial
- ✓ Specialty services available

### **How the Plan Works**

When you enroll in Cigna Dental Care DHMO, you must select a primary care dentist for yourself and your covered dependents. Each covered dependent can choose their own primary care dentist near their home or work.

You must utilize the selected primary care dentist for all of your dental services. If services are not obtained through the primary care dental office, or if Cigna Dental Care has not authorized the services, those services will not be covered. If you require specialty care, your primary care dentist will refer you to a network specialist.

You may request a treatment plan, which outlines your out-of-pocket costs, from your dentist before proceeding with any recommended services.

You may change your dental office for any reason. The change will become effective the first of the following month. To make the change, visit [www.mycigna.com](http://www.mycigna.com) or call Cigna Member Services at (800) 238-5834 to speak with a customer service representative.

### **Copayments**

For most basic and preventative services, you pay no copayment. For other services, you pay a small fee as described on your patient charge schedule.

**Deductible**

You pay no deductibles.

**Claim Forms**

You have no claim forms to file.

**Orthodontia Coverage**

You and your covered dependents may obtain comprehensive and/or limited orthodontic care from any Cigna Dental Care orthodontist of your choice. Pretreatment records and diagnostic services are covered at a \$620 copayment for any proposed treatment phase.

For comprehensive orthodontic treatment, you pay a \$490 startup (banding) fee along with a \$40 copayment per month for 24 months of usual and customary treatment.

The startup (banding) charges for limited and/or interceptive orthodontic treatment is a copayment of \$230 for primary, transitional, and adolescent (to age 19) teeth; and \$430 for adult teeth, with a \$40 copayment per month which covers 24 months of usual and customary treatment.

**Please note:** The 24-month allowance for orthodontic treatment is not on a per-treatment basis; this allowance is based on the lifetime of the plan.

You can obtain a list of Cigna Dental Care orthodontists by calling Cigna Member Services at (800) 238-5834 or by visiting our website at [www.cigna.com](http://www.cigna.com).

**Oral Health Integration Program**

Cigna Dental Oral Health Integration Program (OHIP) provides proactive care to members with medical conditions such as cardiovascular disease, diabetes, and maternity. This program provides enhanced dental coverage to participants enrolled in Cigna Dental plans. Participants may be eligible for additional cleanings per year. To find out if you are eligible for the additional benefits under OHIP, contact Cigna Member Services at (800) 238-5834.

**Out-of-State Dependent Coverage**

If you have covered dependents living outside of California, contact Cigna Member Services at (800) 238-5834 for a list of covered states.

**Emergency Care**

If you need emergency services, call your primary care dental office first. If your primary care dental office is unavailable, call Cigna Dental Care at (800) 238-5834 24 hours a day/7 days a week for assistance.

**Out-of-Area Care**

If you need dental care away from home, call Cigna Member Services at (800) 238-5834 for a listing of network dentists. Member Services will be able to address your specific situation.

**Predetermination of Covered Benefits**

A predetermination is particularly useful for more costly procedures such as crowns, wisdom teeth extractions, bridges, dentures or periodontal surgery. Your dentist may provide you a predetermination of covered benefits detailing the cost (co-payments) for recommended procedures.

## How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 60 days of hire into an eligible position and return it to their payroll specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

Call Cigna Dental Care (DHMO) member services at (800) 238-5834, if you:

- ✓ Need to select a new dentist
- ✓ Have a benefits question
- ✓ Need a provider directory
- ✓ Need a member ID card
- ✓ Have an eligibility question
- ✓ Have a claim question
- ✓ Would like to request predetermination of benefits

## Questions About Your Cigna Dental Coverage Before You Enroll?

Call Cigna Member Services at (800) 238-5834, 24 hours a day/7 days a week.

After you enroll, register at [mycigna.com](http://mycigna.com) to view your personalized dental plan information.

## What's Covered

While covered under the Cigna Dental Care Plan, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to plan exclusions and limitations. Please refer to the Dental Plans Comparison Chart in this guide for a sample of covered expenses. For a comprehensive explanation of benefits, please refer to the plan's Evidence of Coverage Document, which can be found at [http://www.sbcounty.gov/hr/cd\\_plan.aspx](http://www.sbcounty.gov/hr/cd_plan.aspx).

## How to Get In Touch With Cigna Dental Care (DHMO)

For information contact Cigna Member Services at (800) 238-5834 24 hours a day/7 days a week or visit Cigna Dental Care's website at [www.cigna.com](http://www.cigna.com).





## **CIGNA DENTAL PPO**

Cigna Dental PPO allows you to elect care from an in-network (Radius) or out-of-network dental provider. Whether you choose an in-network or out-of-network provider, your coverage includes a wide range of covered services.

Dual coverage is allowed between two County employees enrolled in County-sponsored dental DPPO plans.

### **How the Plan Works**

#### ***In-Network***

When you receive your dental care from a Cigna Dental PPO network dentist, you will pay a percent of the dentist's discounted Cigna Dental PPO rates (0% for preventive services and 0% for basic restorative services).

To find out what your cost will be in advance, your dentist may request a predetermination of benefits from Cigna, or you may contact Cigna Member Services to find out the percentage of coverage offered to you, based on your available annual maximum.

To obtain a Cigna Dental PPO Preferred Provider Directory, please call Cigna Member Services at (800) 238-5834 or visit Cigna's website at [www.cigna.com](http://www.cigna.com).

#### ***Out-of-Network***

When you receive care from an out-of-network dentist, you will pay a percentage (0% for preventive services and 10% for basic restorative services) of Cigna Dental PPO's maximum allowance as established by Cigna Dental.

You will be responsible for the difference between the payment dental providers receive from Cigna Dental and their usual fees. This cost will vary by provider.

For example: Let's assume you had an out-of-network periodontic root planing and your out-of-network dentist charged \$125. If Cigna's maximum allowance for that service was \$100, then you would pay 10% of \$100 (\$10) plus the additional \$25 difference between Cigna's maximum allowance and the dentist's billed amount. This additional cost is referred to as "balance billing." Your total out-of-pocket expense for this procedure would be \$35. If you used a Cigna Dental PPO in-network dentist and the average contracted charge for this procedure is \$85, you would pay 10% of the \$85 (\$8.50). There is no "balance billing" when you access an in-network dentist provider. (Note: the numbers cited are for example purposes only; they may not reflect the actual rates associated with this procedure.)

When you receive out-of-network services, your out-of-pocket expenses will generally be higher. Out-of-network dentists have not agreed to participate in Cigna's DPPO network, in which discounted rates have been negotiated.

#### ***Co-insurance***

Co-insurance varies by procedure. However, most preventive services will be provided at no cost to you from in-network providers (within maximum allowance limitations).

#### ***Deductible***

Under Cigna Dental PPO, you pay no deductible.

### ***Emergency Care***

In an emergency, get the care you need. The plan will pay benefits based on whether your emergency care was received from an in-network or out-of-network dentist. If possible, contact your regular dentist first as they may be able to direct you to another office if theirs is not available.

### ***Orthodontia Coverage***

You and your covered dependents may obtain orthodontic care from any licensed orthodontist of your choice. The plan pays 50% of your orthodontia expenses up to a lifetime maximum of \$1,700.

### ***Oral Health Integration Program***

Cigna Dental Oral Health Integration Program (OHIP) provides proactive care to members with medical conditions such as cardiovascular disease, diabetes, and maternity. This program provides enhanced dental coverage to participants enrolled in Cigna Dental plans. Participants may be eligible for additional cleanings per year. To find out if you are eligible for the additional benefits under OHIP, contact Cigna Member Services at (800) 238-5834.

### ***Out-of-Area Care***

If you need dental care away from home for non-emergency services, call Cigna Member Services at (800) 238-5834. If possible, you will be directed to an in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit, unless it's an emergency.

### ***Predetermination of Covered Benefits***

A predetermination is particularly useful for more costly procedures such as crowns, wisdom teeth extractions, bridges, dentures or periodontal surgery. When your dentist predetermines treatment with Cigna, you'll receive an estimate of your share of the cost and how much Cigna will pay before treatment begins.

To predetermine treatment, your dentist sends Cigna a proposed treatment plan, along with x-rays relevant to the case. Cigna then checks to be sure the services are covered by your dental program. Cigna also calculates how any coinsurance and dollar maximum limits might affect your share of the cost. Your dentist then receives an estimate of the amount Cigna will pay for approved services. Please call Cigna Member Services at (800) 238-5834 to find out how to submit a predetermination of benefits.

### ***Claim Forms***

Under Cigna Dental PPO, in-network dentists will submit a claim form directly to Cigna Dental.

If your dentist is not contracted (out of network) with Cigna Dental, you may have to file your own claims. It is your responsibility to pay your dentist for services rendered and to submit all necessary claim forms.

### ***How to Enroll***

New employees must complete a Dental Plan Enrollment/Change form within the first 60 days of hire into an eligible position, and return it to their payroll specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

Call Cigna Dental PPO member services at (800) 238-5834 if you:

- ✓ Have a benefits question
- ✓ Need a provider directory
- ✓ Need a member ID card
- ✓ Have an eligibility question
- ✓ Have a claim question
- ✓ Would like to request predetermination of benefits

## Questions about your Cigna dental coverage before you enroll?

Call Cigna Member Services at (800) 238-5834, 24 hours a day/7 days a week.

After you enroll, register at [mycigna.com](http://mycigna.com) to view your personalized dental plan information.

## What's Covered

While covered under Cigna Dental PPO, you can take advantage of comprehensive dental benefits.

The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the Dental Plans Comparison Chart on pages 40-43 of this guide for examples of covered expenses. For a comprehensive explanation of benefits, please refer to the plan's Evidence of Coverage Document which can be found at [http://www.sbcounty.gov/hr/cd\\_plan.aspx](http://www.sbcounty.gov/hr/cd_plan.aspx)

**Note:** If more than one covered service will treat a dental condition, payment is limited to the least costly treatment, provided it is a professionally accepted, necessary and appropriate treatment. If you accept or request a more costly covered service, you will be responsible for expenses that exceed the amount covered for the least costly service. This practice is called the **Alternate Benefit Provision** and is described in the plan's EOC. The Alternate Benefit Provision typically applies to crowns, bridges, and dentures. It also applies to white fillings (Resin Composite) on molars when the service is provided by an out-of-network dentist. For this reason, a Predetermination of Covered Benefits is highly recommended before you begin these types of treatments.

It is recommended that you obtain and agree to a prescribed treatment plan issued by your dental provider prior to receiving treatment. To determine if you are being billed the correct copayment amounts, compare the amounts on the treatment plan to the amounts listed in your Evidence of Coverage and/or Patient Charge Schedule.

## How To Get In Touch With Cigna Dental PPO

For information about Cigna Dental PPO, call member services at (800) 238-5834 or visit Cigna's website at [www.cigna.com](http://www.cigna.com).

## DENTAL PLAN COMPARISON CHART

			Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
				Calendar Year Maximum Benefit	Calendar Year Maximum Benefit
				\$1,700 per person (excluding orthodontia)	
Category	Procedure Code	Description	(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Preventive Care	D0120	Periodic oral examination (2 per year)*	No Charge	No Charge	No Charge
	D0210	Full mouth X-ray (see frequency limitations)	No Charge	No Charge	No Charge
	D9110	Emergency, palliative treatment of dental pain	\$5.00	No Charge	No Charge
	D1203	Topical Fluoride (child) – see limitations	No Charge	No Charge	No Charge
	D1110 (Adult) D1120 (Child)	Prophylaxis (cleanings) (1 per 6-month period)*	No Charge	No Charge	No Charge
	D1351	Sealant (per tooth) limitations may apply	\$5.00	No Charge	No Charge
	D1352	Preventive resin restoration – permanent tooth	\$5.00	No Charge	No Charge
Adjunctive General Services	D9972	External bleaching – self-treatment with bleaching tray & gel	\$125.00 per arch	Not Covered	Not Covered
	D9940	Occlusal guard (night guard), by report – limited to 1 in 3 years	\$95.00	25%	30%
	D9951	Occlusal adjustment, limited	\$20.00	No Charge	10%
	D9952	Occlusal adjustment, complete	\$40.00	No Charge	10%
	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50.00	Benefit covered through Medical Plan/Cigna as secondary to medical	Benefit covered through Medical Plan/Cigna as secondary to medical
Restorative Dentistry**	D2140 (1) D2150 (2) D2160 (3) D2161 (4)	Amalgam (“silver” fillings) on primary or permanent teeth: 1, 2, 3 or 4 surfaces	No Charge	No Charge	10%
	D2330 (1) D2331 (2) D2332 (3) D2335 (4)	Resin composite (white fillings), anterior (front) teeth: 1, 2, 3 or 4 surfaces	No Charge	No Charge	10%
	D2391 (1) D2392 (2) D2393 (3) D2394 (4)	Resin composite (white fillings), posterior (molars): 1, 2, 3 or 4 surfaces	\$45.00 \$55.00 \$65.00 \$75.00	No Charge	10%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Restorative Dentistry (continued)	D2510 (1) D2520 (2) D2530 (3 +)	Metallic Inlay – Up to 3+ surfaces	No Charge	25% upon review, predetermination recommended	30% upon review, predetermination recommended
	D2650 (1) D2651 (2) D2652 (3 +)	Composite resin inlay (white) – Up to 3+ surfaces	\$85.00 \$95.00 \$115.00	25% upon review, predetermination recommended	30% upon review, predetermination recommended
	D2610 (1) D2620 (2) D2630 (3 +)	Porcelain/ceramic inlay – Up to 3+ surfaces	\$135.00 \$150.00 \$160.00	25% upon review, predetermination recommended	30% upon review, predetermination recommended
Periodontics	D4241 (1-3) D4240 (4+) (# of teeth)	Gingival flap, per quadrant	\$75.00 \$75.00	10%	10%
	D4263	Bone replacement graft – first site in quadrant	\$195.00	10%	10%
	D4264	Bone replacement graft – each additional site in quadrant	\$60.00	10%	10%
	D4211 (1-3) D4210 (4+) (# of teeth)	Gingivectomy/gingivoplasty (gum surgery), per quadrant	\$15.00 \$75.00	10%	10%
Endodontics	D3220	Pulpotomy	No Charge	No Charge	10%
	D3222	Partial pulpotomy for apexogenesis – permanent tooth	No Charge	No Charge	10%
	D3310	Root canal – Anterior (front) teeth	\$30.00	No Charge	10%
	D3320	Root canal – Bicuspid	\$60.00	No Charge	10%
	D3330	Root canal – Molar	\$90.00	No Charge	10%
Oral Surgery	D7286	Biopsy of soft oral tissue	No Charge	No Charge	10%
	D7140	Uncomplicated extraction, single tooth	No Charge	No Charge	10%
	D7220	Extraction – impacted soft tissue, per tooth	No Charge	No Charge	10%
	D7230	Extraction – impacted partially bony, per tooth	\$30.00	No Charge	10%
	D7240	Extraction – impacted completely bony, per tooth	\$40.00	No Charge	10%
	D9215	Local anesthesia	No Charge	No Charge	No Charge
	D9220	General anesthesia – first 30 minutes (only with oral surgery)	\$165.00	10%	10%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Oral Surgery (continued)	D9221	General anesthesia – each additional 15 minutes (only with oral surgery)	\$80.00	10%	10%
	D7450/D7451	Removal of benign odontogenic cyst or tumor	No Charge	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits
Crowns and Bridges**	D2790	Crown – full cast high noble metal (gold)	\$160.00	25%	30%
	D6721	Crown –resin with predominantly base metal	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6740	Crown – porcelain/ ceramic substrate	\$195.00	25% addt'l cost for porcelain on molar teeth	30% addt'l cost for porcelain on posterior teeth
	D6722	Crown – porcelain fused to noble metal	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6930	Recement fixed partial denture	No Charge	No Charge	10%
	D2920	Recement crown	No Charge	No Charge	10%
	D6241	Pontic – porcelain fused to predominantly base metal (front teeth or molars)	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6980	Fixed partial denture repair, by report	\$15.00	No Charge	10%
Prosthetics**	D5110 (Upper) D5120 (Lower)	Complete upper or lower denture	\$75.00 for either upper or lower	25%	30%
	D5211 (Upper) D5212 (Lower)	Upper or lower partial denture – resin base	\$85.00 for either upper or lower	25%	30%
	D5670 (Upper) D5671 (Lower)	Replace all teeth (upper or lower) on cast metal framework	\$75.00 for either upper or lower	No Charge	10%
	D5510	Repair broken Complete Denture Base	\$15.00	No Charge	10%
	D5410 (Upper) D5411 (Lower)	Complete denture adjustment	No Charge for either upper or lower	No Charge	10%
	D5520	Replace broken tooth on denture	\$5.00	No Charge	10%
	D6010 D6012 D6040 D6050	Implants	Not Covered	25%, predetermination recommended	30%, predetermination recommended

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Orthodontics	D8999	Ortho Treatment Plan and Records	\$620.00	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)
	D8090	Comprehensive orthodontic treatment	\$490.00, plus \$40 per month for usual and customary 24-month treatment	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)
	D8010	Limited ortho treatment of primary, transitional or adolescent teeth	\$230.00, plus \$40 per month for usual and customary 24-month treatment	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)
	D8040	Limited orthodontic treatment of the adult teeth	\$430.00, plus \$40 per month for usual and customary 24-month treatment	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)

\* Additional allowances for these services are available through Cigna's Oral Health Integration Program. Eligible conditions for the program include cardiovascular disease, cerebrovascular disease (stroke), diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation. Contact Cigna Customer Service at (800) 238-5834 for more information.

**\*\***This procedure may be subject to additional costs based on materials used and/or location of the tooth/teeth within the mouth (e.g., see **Alternative Benefit Provision** under What's Covered section. Please refer to your plan's Evidence of Coverage and/or Patient Charge Schedule for detailed information or contact Cigna Dental Member Services at (800) 238-5834.

Notes:

## EYEMED VISION

The County of San Bernardino has contracted with EyeMed Vision Care to provide vision care benefits to its employees. EyeMed is one of the leading managed vision care organizations in the industry.

The County of San Bernardino participates in a comprehensive plan that offers you:

- ✓ Exams, standard lenses or contacts and frames every 12 months
- ✓ No eye exam copayments
- ✓ Large network of vision care providers
- ✓ Freedom to see any provider you choose
- ✓ In- and out-of-network benefits
- ✓ Retinal imaging benefits
- ✓ Additional in-network discounts on frames and items not covered by the plan
- ✓ 40% off on additional pairs of prescription eyewear
- ✓ 15% off Lasik
- ✓ Online service features
- ✓ Customer service representatives available 7 days a week and evenings

EyeMed Vision Care features a full service website that will allow you to access and download valuable information about the company, view benefit details and claim status, locate providers and print ID cards. Register at their web address, <https://www.eyemed.com>. To locate a provider near you, use the "locate a provider" tool. Choose the "Select" network, then enter your ZIP code.

### What's Not Covered

The following is a list of limitations and exclusions for services that are not covered under the plan:

1. Charges for procedures, services or materials that are not included as Covered Charges.
2. Any portion of a charge in excess of the Maximum Benefit Allowance.
3. Orthoptic or vision training, subnormal vision aids, Aniseikonic lenses, and any associated supplemental training.
4. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
5. Corrective eye wear required as a condition of employment.
6. Safety eye wear unless specifically covered under the Policy.
7. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions.
8. Plano (nonprescription) lenses.
9. Nonprescription sun glasses, except for 20% discount.



10. Two pair of glasses in lieu of bifocals.
11. Services or materials provided by group benefit providing vision care.
12. Certain frame brands in which the manufacturer imposes a no-discount policy.
13. Services and materials for replacement or repair of lost or broken lenses, frames, glasses, or contact lenses.

If you are enrolled in more than one EyeMed Vision Care plan, you will receive the benefits of the plan that is presented at the time of service; the benefits do not coordinate.

### **How to Get in Touch with EyeMed Vision Care**

For further information, please contact the EyeMed Customer Care Center at (877) 406-4146. Service Representatives are available daily from 4:30 a.m. to 8:00 p.m. (PST).



## COBRA CONTINUATION COVERAGE

### General Information

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1985 to offer employees and their covered dependents the opportunity to elect a temporary continuation of their plan coverage in certain instances where coverage would otherwise end. The benefit plans maintained by the County are administered in accordance with the regulations and laws specified by COBRA.

Employees and covered family members will receive a COBRA General Notice upon enrollment in a medical, vision and/or dental plan. The COBRA General Notice explains your COBRA rights and obligations in the event that you or your family members lose coverage maintained by the County.

Upon notification that you or a family member has lost coverage, EBSD will mail you additional information and the appropriate election notices.

### Qualified Beneficiary

For purposes of COBRA, a qualified beneficiary is an individual who, on the day before the qualifying event, is covered under the benefit plans maintained by the County of San Bernardino by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee.

For purposes of COBRA, Domestic Partners are not considered to be qualified beneficiaries, but may be eligible to enroll as a dependent of a qualified beneficiary.

### Qualifying Events

If you are an employee of the County and are covered by the benefit plans maintained by the County, you have the right to elect COBRA continuation coverage if you lose coverage due to any one of the following qualifying events:

- ✓ Termination of your employment (for reasons other than gross misconduct)
- ✓ Reduction in the hours of your employment

If you are the spouse of an employee and are covered by the benefit plans maintained by the County, you have the right to elect continuation coverage if you lose coverage due to any of the following qualifying events:

- ✓ The death of the employee
- ✓ Voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in spouse's or domestic partner's hours of employment with the County of San Bernardino
- ✓ Divorce or dissolution of domestic partnership

An employee's dependent child who is covered by the benefit plans maintained by the County has the right to elect continuation coverage if coverage is lost due to any of the following qualifying events:

- ✓ The death of the employee (parent)
- ✓ Termination of the employee (parent) (for reasons other than gross misconduct) or reduction in the employee's (parent's) hours of employment with the County of San Bernardino
- ✓ Parent's divorce or dissolution of domestic partnership
- ✓ The child ceases to be a "dependent child" under the terms of the benefit plans

## COBRA Rights and Obligations

### ***Individual Election Rights and Eligibility***

Each individual who was covered under a County-sponsored benefit plan on the day before the qualifying event is a qualified beneficiary and has independent election rights to continuation coverage. This means that each dependent who was covered can elect to continue coverage, even if the covered employee chooses not to continue coverage. However, continuation coverage is available to qualified beneficiaries subject to their continued eligibility. For purposes of COBRA, Domestic Partners are not considered to be qualified beneficiaries, but can be enrolled for COBRA coverage subject to election, eligibility and plan rules applicable to the qualified beneficiary. The Human Resources Benefits Chief, Employee Benefits and Services Division of the County of San Bernardino, or designee, reserves the right to verify eligibility status and terminate continuation coverage back to the original COBRA effective date, if it is determined that an individual is ineligible or coverage was obtained through a material misrepresentation of the facts.

County sponsored health plans are not “bundled” and are independent of one another. As such, under the provisions of COBRA, each qualified beneficiary can elect to continue all health plans or any combination of plans in which they were enrolled the day before the event. For instance, a qualified beneficiary could elect to continue their group medical coverage and waive the continuation of their group dental coverage. The applicable premiums will vary depending on the coverages elected.

Once an election of continuation coverage is made, the plans that you are able to enroll in may change if modifications are made to the plans available to similarly situated non-COBRA plan participants.

Once enrolled, if your marital status changes, if a covered dependent ceases to be eligible for coverage, or if the address of you or your spouse changes, you must notify EBSD immediately. New dependents will not be entitled to COBRA if EBSD is not notified within 60 days of qualifying event.

### ***Election Period***

If you or your dependents experience a COBRA qualifying event, you will receive a COBRA Election Notice which will provide the details of your current coverage. You may elect any combination of coverage, in whole or in part, that meets your needs. You and your dependents will have 60 days from date of notification to elect COBRA coverage.

To elect COBRA, you and/or your dependents need to submit the election form within the 60-day election period. You will not be covered under the plan(s) until an election is made and all applicable premiums are paid. Once premiums are paid, your coverage will be retroactively reinstated back to your loss of coverage date.

If you choose not to elect COBRA coverage for one or all County-sponsored medical, dental, and/or vision plans, your eligibility and rights for COBRA coverage specific to the plans declined will be considered “waived” based on the non-election made.

After your election form is received by EBSD, you will be sent a Confirmation of Election statement detailing your applicable election, premium amounts, and applicable due dates.

***COBRA rules and regulations are subject to changes in state and federal law. if any provision contained in this benefit guide is found to be in conflict with the current laws, applicable state or federal laws shall prevail.***

### ***Paying for COBRA***

COBRA premiums are not paid by the County. As a qualified beneficiary you are responsible for paying the full premium of the elected COBRA coverage. COBRA premiums reflect the total cost of County-sponsored coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus an additional administrative fee of up to 2% (for a maximum total of 102%) as allowed under federal law.

The initial premium payment must be made within 45 days after the date of the COBRA election. Premiums for successive periods are billed in monthly increments and are due on the first day of the month of coverage.

If premiums are not received or postmarked by the required due dates, coverage will be retroactively cancelled back to the date for which coverage was last paid and COBRA rights and protections will be forfeited.

### ***Coverage Period***

In general, qualified beneficiaries are eligible to continue medical, dental, and vision coverage for a maximum consecutive period of eighteen (18) months from the qualifying event date.

At the end of the COBRA coverage period, you will be notified of your option to continue coverage under Cal-COBRA if applicable. Under Cal-COBRA an extension of medical coverage is available for up to 18 additional consecutive months (dental and vision coverage is not available under Cal-COBRA).

For additional information on specific coverage periods applicable to your situation, contact EBSD.

### ***New Dependents and Open Enrollment***

If, during the period of COBRA coverage, an employee who elected continuation coverage acquires new dependents (such as through marriage), the new dependents may be added to the coverage according to the rules of the plan. However, the new dependents do not gain the status of a qualified beneficiary and will lose coverage if the qualified beneficiary who added them to the plan loses coverage. Plan procedures for adding new dependents are available by calling EBSD.

In addition, should an Open Enrollment period occur during your COBRA continuation period, the County will notify you of your Open Enrollment rights. Each qualified beneficiary will have independent election rights to select any of the options or plans that are available to similarly situated non-COBRA plan participants during the Open Enrollment period.

If you are enrolled in COBRA during the Open Enrollment period, you may make changes to your current coverage. This includes changing your coverage levels (e.g. adding or dropping dependents), changing from HMO to PPO (within same provider), or switching medical providers.

You will not be able to make an election to participate in coverage that you have previously waived. For example, if you elected COBRA continuation coverage for medical but not vision or dental you will have Open Enrollment rights for medical only and will not be able to re-enroll in a dental or vision plan.

### ***Cancellation of Continuation Coverage***

COBRA continuation coverage can end prior to the exhaustion of the applicable maximum months of continuation coverage for any of the following reasons:

- ✓ A qualified beneficiary notifies the County they wish to cancel continuation coverage;
- ✓ The County ceases to provide any benefit plan to any of its active employees;
- ✓ Any required premium for continuation coverage is not paid in a timely manner;
- ✓ A qualified beneficiary becomes covered under another group health plan after electing COBRA; health plan must not contain any exclusion or limitation with respect to pre-existing conditions;
- ✓ A qualified beneficiary becomes entitled to Medicare after electing COBRA;
- ✓ For cause (e.g., for submitting fraudulent claims), on the same basis that the plan terminates the coverage for cause of similarly situated non-COBRA participants

### ***Certificate of Creditable Coverage***

A Certificate of Creditable Coverage is provided to you when you experience a COBRA qualifying event. It will detail the amount of time you have been covered under the County's group health insurance plan(s). The Certificate of Creditable Coverage may be used as proof of a qualifying event that permits mid-year enrollments under other group-sponsored health plans.

If you elect COBRA coverage, an updated Certificate of Creditable Coverage will be sent to you when your COBRA coverage ceases. If you lose or do not receive the above-mentioned certificate, one can be requested up to 24 months from the date coverage (or COBRA coverage) is lost by calling (909) 387-5552, emailing [ebdsd@hr.sbcounty.gov](mailto:ebdsd@hr.sbcounty.gov), or sending a request to the COBRA Plan Administrator at:

County of San Bernardino  
Human Resources Department  
Employee Benefits and Services Division  
157 W. Fifth Street, First Floor  
San Bernardino, CA 92415-0440

### ***Alternative to COBRA***

Besides COBRA continuation coverage, you are now eligible to purchase individual health insurance through the Health Insurance Marketplace. In the Marketplace, you can see what your premium, deductibles, and out-of-pocket costs will be for a variety of individual health plans before you make a decision to enroll. In addition, you may be eligible for a new tax credit that lowers your monthly premiums. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. Premiums for health insurance purchased in the Marketplace may be higher or lower than the premiums for COBRA. If you elect COBRA, you will be eligible to enroll in a plan through the Marketplace during its annual open enrollment period or upon exhaustion of your continuation coverage. For more information about health insurance options available through a Health Insurance Marketplace, visit <http://www.healthcare.gov/>

### ***How to Get in Touch with a COBRA Representative***

Call EBSD at (909) 387-5552 or email [ebdsd@hr.sbcounty.gov](mailto:ebdsd@hr.sbcounty.gov).

## MEDICAL EXPENSE REIMBURSEMENT PLAN (FSA)

The County of San Bernardino offers a Medical Expense Reimbursement Plan, also known as a Flexible Spending Account (FSA), that allows employees to take a pre-tax deduction from their income to pay for eligible medical care expenses. This allows an immediate tax savings.

Employees are eligible to participate in the FSA if they are covered under a MOU, Compensation Plan, Employment Contract, or Contract with an entity that expressly provides eligibility for the FSA.

### How the Plan Works

Eligible employees elect an annual contribution amount to be placed in the FSA. The annual contribution is made via bi-weekly payroll deductions in equal installments throughout the year. The amount contributed to the FSA will not count as taxable income, which provides employees immediate tax savings. Participants can access their FSA money by: 1) Using their FSA benefit card to pay for eligible medical expenses, eliminating the need to file a claim, or 2) Submitting a claim (paper or electronic) and required documentation. Once a claim is substantiated, money is deposited directly into participant's bank account on file. Expenses must be incurred during the plan year to be eligible for reimbursement.

### Elections

Participants may enroll in the FSA:

- ✓ During the annual Open Enrollment period each year
- ✓ Within sixty (60) days of a Section 125 qualifying change-in-status event. The requested FSA election change must be consistent with the event. This may include but is not limited to the following mid-year change-in-status events:
  - Commencement of County employment (New Hire)
  - Hired into a position that makes you newly eligible to participate in the FSA or increases your benefit plan (e.g. employer match)
  - Marriage
  - Divorce or legal separation
  - Death of spouse or dependent
  - Birth or adoption of a child or placement for adoption/guardianship
  - Termination of spouse's employment
  - Commencement of spouse's employment

FSA plan elections are only valid for the current plan year. Plan participants must elect to enroll each year in order to continue participation.

Per IRS regulations, a participant's election is irrevocable. Participants may not revoke or change their election for the remainder of the Plan Year unless a qualifying mid-year change-in-status event is experienced. The requested FSA election change must be consistent with the event. For more information regarding mid-year change in status events, refer to the Section 125 Premium Conversion Plan section contained within this guide.

## Contribution Limits

Effective July 25, 2015, the annual maximum contribution is \$2,550 pursuant to IRS regulations. Participant's minimum and maximum contribution amounts correspond with their bargaining unit's allowable contributions, which may not coincide with the IRS maximum. Please refer to the appropriate MOU, Exempt Compensation Plan, Salary Ordinance, or Contract for specific minimum and maximum contribution limits.

## Use it or Lose It

Be as accurate as possible when estimating the total annual FSA contribution amount. Do not contribute more money into the FSA than will be used as it is subject to forfeit. Forfeited funds will be applied toward the cost of administering the plan.

In 2014, the IRS issued a new ruling for FSA that allows the option for Employers to implement a rollover of up to \$500 of participant funds remaining in their FSA Account at the end of each year. Any unused amounts in excess of \$500 will be forfeited.

Effective May 5, 2015, the County amended the FSA Plan Document to allow this option for County FSA plan participants if their MOU, Compensation Plan, Salary Ordinance, or Employment Contract also allows for it.

## What does this mean to me?

If your MOU, Compensation Plan, Salary Ordinance, or Employment Contract allows for the \$500 rollover, you will be allowed to roll FSA balances up to \$500 remaining at the end of each plan year. As of current date, the following groups have this language:

- ✓ Elected Officials
- ✓ Exempt
- ✓ Exempt, Special District/County Fire
- ✓ Firefighters, Local 935
- ✓ Fire Management Unit
- ✓ General Fire Support
- ✓ General SBPEA (Excludes Professional)
- ✓ Nurses and Per Diem Nurses
- ✓ Probation
- ✓ Special District/County Fire Non Represented Employees
- ✓ Water and Sanitation

This provision will automatically be applied to plan participants in the bargaining units above who make an FSA election beginning in the 2015-16 plan year. Upon a confirmed 2015-16 election, up to \$500 of a participant's remaining 2014-15 FSA account funds will automatically be rolled over into their 2015-16 FSA account.

For plan participants in bargaining units not listed above, the provision will be applied as it becomes available in the participant's MOU, Compensation Plan, Salary Ordinance, or Employment Contract. The provision can only be applied prior to the end of the current plan year. If the provision is made available after the end of the plan year, it will not be applied until the following plan year.



## Eligible Expenses

Pursuant to IRC Section 213, expenses are generally considered eligible for reimbursement if the expense(s):

- ✓ are incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness.

Expenses are generally not considered eligible for reimbursement if the expense(s) are:

- ✓ solely for cosmetic reasons
- ✓ general health improvement products or services (e.g. health spas, gym memberships, vitamins, etc.)
- ✓ over-the-counter medicines (e.g. pain relievers, allergy pills, etc.)

Please note general health products/services and over-the-counter medicines may be considered an eligible expense if an FSA verification of medical necessity or prescription (OTC medications only) completed by a provider establishing that such products/services meet IRC Section 213 requirements listed above is provided with a claim or is on file with EBSD and meets the requirements listed under the Claims Filing and Supporting Documentation section below.

A list of most common eligible expenses is available on the County's FSA intranet or internet sites at <http://mybenefitsatwork> or [www.sbcounty.gov/hr](http://www.sbcounty.gov/hr)

Mileage may be claimed for reimbursement for travel to and from the provider or vendor where the eligible medical expense was incurred. Please note: the medical mileage reimbursement rate used is in accordance with the rate established by the IRS each year.

## Participant Portal

FSA participants will have access to the online FSA/DCAP Participant Portal 24 hours a day/7 days a week. The Participant Portal gives participants secure access to their account to:

- ✓ Check account balances
- ✓ View claims and payment details
- ✓ File claims and submit receipts online
- ✓ View upcoming reimbursements
- ✓ View notifications

New participants will receive an email with a link to the online portal to create a username and password. To retrieve lost usernames or passwords, participants can go to the portal and reset their information. The portal can be found at <https://sbchr.lh1ondemand.com/Login.aspx?ReturnUrl=%2f>

## Benefit Card (Benny Card)

Employees who enroll in the FSA will be mailed two benefit cards (Benny Cards) to be used by employees and their dependent(s) to pay for eligible medical expenses. When the Benny Card is used, payments will be automatically withdrawn from the participant's FSA, eliminating out-of-pocket expenses and the need to submit claims.





Please note that participants do not need to submit claims for purchases made with a Benny Card; however, participants may be asked to submit additional documentation to complete the substantiation process.

Benny Cards can be used for up to three plan years and will be reloaded each year upon re-enrollment in the plan. FSA participants who also participate in the Dependent Care Assistance Program (DCAP) will be issued one pair of Benny Cards to pay for both medical and dependent care expenses.

Participants can report a lost or stolen card on the FSA/DCAP Participant Portal or by calling (888) 743-1474. New cards are subject to a \$10 replacement fee, which will be deducted from the available balance in the participant's FSA.

## Claims Filing and Supporting Documentation

All claims for reimbursement are subject to review and require both a claim reimbursement form and supporting documentation in order to be processed for approval.

Participants also have the option to file electronic or paper claims.

- ✓ Electronic: File claim and upload supporting documentation (e.g. receipts) online via the FSA/DCAP Participant Portal. If claiming mileage via online form, participant must upload a print out of an online map source (e.g. MapQuest) that includes the starting and ending destination points and total miles traveled.
- ✓ Paper: File paper reimbursement claim form and copies of supporting documentation. If claiming mileage, the mileage expense worksheet section of the Medical Expense Reimbursement (FSA) Plan Claim form must be completed.

Claimed expenses must clearly indicate for whom expense(s) is being incurred must be itemized per individual, and should not be listed as a combined expense. Below is a brief description of the information that should be provided on the claim information form. Supporting documentation from the provider, vendor, or merchant (independent third parties) should clearly demonstrate the information listed on the claim form in order for EBSD to substantiate claimed expenses. For additional information on filing claims, please refer to the FSA Plan Summary Description.

Note that canceled checks to providers, vendors, or merchants are not sufficient as stand-alone documentation as they do not satisfy the independent third party documentation requirements.

Claims for reimbursement require the following:

- ✓ date of service(s) or sale(s)
  - for services/treatment (e.g. office visit) list the date participant or eligible dependent incurred service/treatment from a provider, do not list the date you paid for service
  - for sales list the date product was purchased a product from a merchant or vendor amount claimed for reimbursement
- ✓ amount claimed for reimbursement of service/treatment or sale incurred
- ✓ indicate the amount paid or billed for the services received or product purchased
- ✓ provider or merchant name
- ✓ expense category (e.g. medical expense, dental, vision, etc.)
- ✓ type of expense (e.g. office visit, orthodontic, prescription eyeglasses, over-the-counter medicines etc.)
- ✓ name of person who expense (e.g. treatment/service/sale) was incurred for

In addition to the above, supporting documentation from the provider, vendor, or merchant (e.g. receipt, statement, or bill) must include the following:

- ✓ description of service or product rendered
- ✓ payment received for expense
- ✓ amount paid to other party (e.g. insurance) for expense
- ✓ for manual claims in which mileage has been claimed a print out of an online map source (e.g. MapQuest) that includes the starting and ending destination points and total miles traveled

When requesting reimbursement for over-the-counter medicines (OTC) or a general health expense the claim must include the following documentation:

OTC Medicines:

- ✓ A legal prescription for the OTC medicines. Prescription must include contain date issued, patient name, provider's address and license number, medication name, duration of prescription including recommended dosage or number of refills.

General Health:

- ✓ A letter of medical necessity (lmn) completed by a provider establishing that a specific product and/or service is medically necessary to cure, mitigate, treat, or prevent a disease and will be primarily used to alleviate or prevent a physical or mental defect or illness.

## Run-out period

Claims for eligible expenses incurred within the plan year can be submitted for reimbursement no later than ninety (90) days after the end of the plan year.

## Reimbursement

In accordance with the County's Direct Deposit Policies, FSA reimbursements will only be issued via Direct Deposit. Your FSA claim reimbursement(s) will be deposited in participant's balance account on file with EMACS. Participants can view their designated balance account via EMACS – Self Service or the FSA/DCAP Participant Portal. In the case of unforeseen circumstances that impact a participant's account (e.g. identity theft), participants will be able to request that funds be issued via check for the duration of one pay period.

**NOTE:** This is only a summary and partial listing of FSA Plan benefits, terms, conditions, exclusions and limitations. For a full and complete listing, please refer to the plan document. If any differences appear between this benefits guide and the plan document, the information in the plan document shall govern.

For more information on benefit card substantiation, direct deposit, claims filing, and the participant portal, please visit the County's FSA intranet or internet sites at <http://mybenefitsatwork> or [www.sbccounty.gov/hr](http://www.sbccounty.gov/hr) and/or refer to the Summary Plan Description and Plan Document.

***FSA rules are governed by Internal Revenue Code Section 125 regulations and subject to any changes in the applicable law. If any provision contained in the plan document is found to be in conflict with the current laws, applicable Internal Revenue Code Section 125 law shall prevail.***

## DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

The County of San Bernardino offers a Dependent Care Assistance Plan (DCAP) that allows employees to take a pre-tax deduction from their income to pay for eligible dependent care expenses. This allows an immediate tax savings to be realized.

Employees are eligible to participate in the DCAP if they are covered under a MOU, Compensation Plan, Employment Contract or Contract with an entity that expressly provides eligibility for the DCAP.

Please note, unlike other County benefits, the DCAP Open Enrollment period is in November of each year, and the DCAP Plan Year matches the calendar year. The DCAP plan year effective date is January 1, each year.

### How the Plan Works

Eligible employees elect an annual contribution amount to be placed in the DCAP account. The annual contribution is made via bi-weekly payroll deductions in equal installments throughout the year. The amount contributed to the DCAP account will not count as taxable income, which provides employees immediate tax savings. Participants can access their DCAP money by:

1. Using their DCAP benefit card to pay for dependent care expenses, eliminating the need to file a claim.
2. Submitting a claim (paper or electronic) and required documentation; once claim is substantiated, money is deposited directly into participant's bank account on file.

Expenses must be incurred during the plan year to be eligible for reimbursement. Participants are charged a nominal fee of .70 cents per pay period to cover administrative costs.

### Elections

Eligible employees may enroll in the DCAP:

- ✓ During the annual DCAP open enrollment period in November each year
- ✓ Within sixty (60) days of a Section 125 qualifying change-in-status event. The requested DCAP election change must be consistent with the event. This may include but is not limited to the following:
  - Commencement of County employment (New Hire)
  - Marriage
  - Divorce or legal separation
  - Death of spouse or dependent
  - Birth or adoption of a child or placement for adoption/guardianship
  - Termination of spouse's employment
  - Commencement of spouse's employment

DCAP plan elections are only valid for the current plan year. Plan participants must elect to enroll each year in order to continue participation.

Per IRS regulations, a participant's election is irrevocable. Participants may not revoke or change their election for the remainder of the Plan Year unless a qualifying mid-year change-in-status

event is experienced. The requested DCAP election change must be consistent with the event. For more information regarding mid-year change in status events, refer to the Section 125 Premium Conversion Plan section contained within this guide.

## Maximum Contribution

The maximum annual contribution for the calendar year is the lowest of either:

- ✓ the participant or spouse's earned income or \$5,000 for married couples filing jointly;
- ✓ \$5,000 for single persons; or \$2,500 for married couples filing tax returns separately; or
- ✓ the earned income of the participant or participant's spouse.

If participant's spouse also participates in the DCAP, the annual maximum includes any benefits he or she received under the DCAP.

## Use It or Lose It

Be as accurate as possible when estimating the total annual DCAP contribution amount. Do not contribute more money into the DCAP than you know will be used as it is subject to forfeit. Forfeited funds will be applied toward the cost of administering the plan.

## Eligible Expenses

Pursuant to IRC Section 129, expenses are considered eligible for reimbursement if the expense:

- ✓ enables the gainful employment of participant or participant's spouse
- ✓ is paid on behalf of a qualified dependent
- ✓ is incurred for dependent care that is provided by an eligible care provider

Expenses that are not eligible for reimbursement under the DCAP include expenses paid for dependent care which do not enable the participant or participant's spouse to work; expenses paid to a person who the participant or participant's spouse are entitled to claim as an exemption for federal income tax purposes; tuition or education expenses for a child in kindergarten or above; fees paid to participant or spouse's child who is age 18 or younger for babysitting; overnight care at a convalescent nursing home for a dependent relative; overnight camp; or expenses for lessons, tutoring or transportation.

## Qualified Dependent

A qualified dependent under the DCAP is a dependent that a participant can claim for federal tax purposes and is:

- ✓ Participant's child who was under age 13 when care was provided and lived with participant for more than half of the calendar year.
  - The child must be the participant's son, daughter, stepchild, sibling, stepsibling, or a descendant of any such individual, eligible foster child, legally adopted child, or a child lawfully placed with participant for adoption.
  - The child must not have provided over one half of their support during the calendar year.
- ✓ Your spouse, relative or child over the age of 12, who is physically or mentally incapable of self-care, lived with participant for more than half of the calendar year, and regularly spends at least eight (8) hours each day in participant's household.

## Eligible Dependent Care Provider

Eligible dependent care providers include the following:

- ✓ A licensed daycare center (must care for more than six children who do not live at the daycare center)
- ✓ A private babysitter
- ✓ An elderly or handicapped care center
- ✓ In-home medical attendant care

Note: You must provide the name, address and tax identification number of your dependent care provider on all claims and on your tax return.

## Participant Portal

DCAP participants will have access to the online FSA/DCAP Participant Portal 24 hours a day/7 days a week. The Participant Portal gives participants secure access to their account to:

- ✓ Check account balances
- ✓ View claims and payment details
- ✓ File claims and submit receipts online
- ✓ View upcoming reimbursements
- ✓ View notifications

New participants will receive an email with a link to the online portal to create a username and password. To retrieve lost usernames or passwords, participants can go to the portal and reset their information. The portal can be found at <https://sbchr.lh1ondemand.com/Login.aspx?ReturnUrl=%2f>

## Benefit Card (Benny Card)

Employees who enroll in the DCAP will be mailed two benefit cards (Benny Cards) to be used by employees and their dependent(s) to pay for eligible dependent care expenses. When the Benny Card is used, payments will be automatically withdrawn from the participant's DCAP account. The amount available to pay for dependent care expenses is equivalent to or less than participant's available account balance. The dependent care provider must accept Visa payments to use the Benny Card option.



Please note that participants do not need to submit claims for purchases made with a Benny Card; however, participants may be asked to submit additional documentation to complete the substantiation process.

Benny Cards can be used for up to three plan years and will be reloaded each year upon re-enrollment in the plan. DCAP participants who also participate in the Medical Reimbursement Plan (also known as the Flexible Spending Account or FSA) will be issued one pair of Benny Cards to pay for both medical and dependent care expenses.

Participants can report a lost or stolen card on the FSA/DCAP Participant Portal or by calling (888) 743-1474. New cards are subject to a \$10 replacement fee, which will be deducted from the available balance in the participant's FSA.

## Claims Filing and Supporting Documentation

Dependent Care expenses not paid for with the Benny Card can be claimed for reimbursement by submitting either electronic or paper claims. DCAP funds will be made available in an amount that is equivalent to or less than participant's available account balance. Eligible claims for reimbursement that exceed the available account balance will be paid out as funds become available each pay period until your claim has been fully reimbursed or the annual election amount is met. All claims for reimbursement are subject to review and require both a claim reimbursement form and supporting documentation in order to be processed for approval.

Participants have the option to file either electronic or paper claims.

- ✓ Electronic: File claim and upload supporting documentation (e.g. receipts) online via the FSA/DCAP Participant Portal.
- ✓ Paper: File paper reimbursement claim form and copies of supporting documentation.

Claimed expenses must clearly indicate for whom expenses is incurred and be itemized per individual and should not be listed as a combined expense. Below is a brief description of the information that should be provided on the claim information form. Supporting documentation from the dependent care provider (independent third party) should clearly demonstrate the information listed on the claim form in order for EBSD to substantiate claimed expenses. For additional information on filing claims, please refer to the DCAP Plan Summary Description.

Note that canceled checks to dependent care providers are not sufficient as stand-alone documentation as they do not satisfy the independent third party documentation requirements.

Claims for reimbursement shall contain the following:

- ✓ name, date of birth, and relation of dependent for whom expense was incurred
- ✓ name, address, and taxpayer ID or social security number of dependent care provider
- ✓ dates of service (cannot claim future dates of services)
- ✓ amount claimed for reimbursement of dependent care expenses incurred
  - indicate the amount paid for the expenses

Supporting documentation from the dependent care provider (e.g. receipt, statement, or bill) must include the following:

- ✓ dates of service (cannot claim future dates of services)
- ✓ description of services rendered
- ✓ payment received for services rendered

## Run-out period

Claims for eligible expenses incurred within the plan year can be submitted for reimbursement no later than ninety (90) days after the end of the plan year.

## Reimbursement

DCAP reimbursements will only be issued via Direct Deposit. DCAP claim reimbursement(s) will be deposited in a participant's balance account on file with EMACS. Participants can view their designated balance account via EMACS – Self Service or the FSA/DCAP Participant Portal. In the case of unforeseen circumstances that impact a participant's account (e.g. identity theft), participants will be able to request that funds be issued via check for the duration of one pay period.

**NOTE:** This is only a summary and partial listing of DCAP Plan benefits, terms, conditions, exclusions and limitations. For a full and complete listing, please refer to the plan document and summary plan description. If any differences appear between this summary and the plan document, the information in the plan document shall govern.

For more information on benefit card substantiation, direct deposit, claims filing, and the participant portal, please visit the County's FSA intranet or internet sites at <http://mybenefitsatwork> or [www.sbcounty.gov/hr](http://www.sbcounty.gov/hr) and/or refer to the Summary Plan Description and Plan Document.

## SHORT-TERM DISABILITY (STD)

The County provides STD benefits to employees in the event of a non-work-related illness or injury that requires the employee to be off work more than seven (7) consecutive calendar days. STD benefits provide partial income replacement while the employee is off work. These benefits may be integrated with the employee's available leave accruals, and are paid and administered by Standard Insurance Company (The Standard).

### Eligibility

Your MOU, Exempt Compensation Plan, Salary Ordinance, or Contract governs your eligibility for STD.

If you belong to one of the eligible groups, your coverage under the plan is automatic. Your bargaining unit has negotiated this benefit on your behalf to replace State Disability Insurance (SDI).

However, employees who participated in SDI at any time within the 18 months immediately prior to filing an STD claim, or employees who have a second job that participates in SDI, may be eligible to receive SDI benefits. The STD benefit amount will be reduced by the amount of the SDI benefit the employee is eligible for or receiving. In the event that the SDI benefit amount is greater than the allowable STD benefit amount, a weekly minimum benefit of \$25.00 will be payable.

With the exception of Fire Management Unit and County/Fire/Special District Exempt employees, in order to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular position budgeted for 40 hours or more per pay period; 2) Employee must have completed at least two pay periods of continuous service, each with a minimum of one-half plus one hour of scheduled hours of paid time; and 3) Employee must be designated as a member of one of the groups covered by this Plan.

In order for Fire Management Unit and County/Fire/Special District Exempt employees to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular County position budgeted for 40 hours or more per pay period; 2) Employee must have completed at least one pay period of continuous service; and 3) Employee must be designated as an Exempt employee or expressly approved for Plan coverage by the County Board of Supervisors.

### Filing a Claim

**No later than your fourth day of absence**, call The Standard directly at (844) 239-3560, or file your claims online at [www.standard.com](http://www.standard.com)

You must also obtain the County required paperwork (RESSL and Leave Integration Request forms) from your payroll specialist or download the forms from the intranet at <http://countyline/emacs/forms.asp>. Your completed paperwork must be returned to your payroll specialist within 15 days after your initial disability date.



## Benefit Payments

After you have satisfied a seven (7) consecutive calendar day waiting period, you are eligible to receive STD benefits. Generally, your normal weekly benefit will be fifty-five percent (55%) of your base salary, not to exceed \$1,104 per week for represented employees, or \$1,574 per week for Fire Management Unit and County/Fire/Special District Exempt employees. These amounts are subject to change. Benefits due for any partial weeks will be calculated at the daily amount of one-seventh (1/7) of the normal weekly benefit. Your normal weekly benefit will be reduced by the amount you receive or are entitled to receive from:

1. State Disability Insurance (SDI) payments
2. Other County-sponsored benefit plan or County recognized union plan payments
3. Other sources of income as provided in the group policy. See your Certificate for the complete list of deductibles.

The maximum benefit period for which an employee covered by the Represented STD Plan may receive for any one (1) disability claim is up to fifty-two (52) weeks. Fire Management Unit and County/Fire/Special District Exempt employees may receive benefits for a maximum benefit period of one-hundred eighty (180) days.

**NOTE:** STD Benefit payments will be made separately by The Standard, and are paid as taxable income.

## Integration of Benefits

Plan Benefit payments may be fully or partially integrated with other paid time including, but not limited to, sick leave, vacation leave, holiday leave, and regular work hours. Employees may not receive more than 100% of their base salary. Employees who elect to fully integrate Plan Benefit payments with other paid time will receive benefits and accruals as specified in the applicable MOU, Exempt Compensation Plan, Contract, or Salary Ordinance as if they were receiving full regular pay. If an employee elects not to fully integrate, or is not eligible to fully integrate, only paid time recorded will be attributable toward benefits eligibility and accruals. Employees may also elect not to integrate any other paid time with Plan Benefits. All benefits and accruals will be administered in accordance with the applicable MOU, Exempt Compensation Plan, Contract, or Salary Ordinance.

If you have a Family Medical Leave Act (FMLA) claim that is concurrent with an STD claim, you may be eligible to receive flexible benefit plan dollars and/or medical premium subsidy in accordance with the applicable MOU, Exempt Compensation Plan, Contract or Salary Ordinance during your leave.

For any questions or additional information regarding Short-Term Disability, contact EBSD at (909) 387-5787, The Standard at (844) 239-3560, or go online to [http://www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx) or <http://mybenefitsatwork> or email [ebd@hr.sbcounty.gov](mailto:ebd@hr.sbcounty.gov).

## LONG-TERM DISABILITY (LTD)

Long-Term Disability is a County-paid benefit that provides partial income replacement for Fire Management Unit and County/Fire/Special District Exempt employees and Contract employees with Exempt benefits that are unable to work due to own disability. The benefit pays 60% of monthly salary but cannot exceed \$10,000.

Payments begin after 180 consecutive days of disability. Plan benefit payments may NOT be fully or partially integrated with other paid time. Maximum duration for which benefits may be paid is as follows:



Age When Disabled	Benefits Payable
Prior to Age 60	To Age 65
Ages 60 – 64	60 months
Ages 65 – 67	To Age 70
Age 68 and over	24 months

For further information contact EBSD at (909) 387-5787 or email [ebsd@hr.sbcounty.gov](mailto:ebsd@hr.sbcounty.gov). To file a claim, contact The Standard at (844) 239-3560, or visit their website at [www.Standard.com](http://www.Standard.com)

## MEDICAL EMERGENCY LEAVE

The purpose of the Medical Emergency Leave (MEL) plan is to allow the unused accrued leave of one County employee to be voluntarily donated for use by another County employee, who has exhausted all of his or her earned leave due to a long-term serious medical condition.

### Eligibility Criteria

To be eligible to participate in the MEL plan, employees must have regular status with the County of San Bernardino or one (1) year of continuous service in a regular position with the County. Refer to your applicable MOU, Compensation Plan, Salary Ordinance or Contract for detailed eligibility provisions.

The employee must meet all of the following criteria before he or she becomes eligible to receive MEL donations under this plan.

1. Be on an approved medical leave of absence for at least thirty (30) consecutive calendar days (160 working hours) exclusive of an absence due to a work related injury/illness;
2. Have exhausted all usable leave balances prior to initial eligibility-subsequent accruals will not affect eligibility;
3. Have recorded at least forty (40) hours of sick leave without pay during the current period of disability; and
4. Submit a Physician's Statement verifying the medical requirement to be off work for a minimum of thirty (30) calendar days (160 working hours).

Employees covered under Safety, Safety Management and Supervisory unit, Firefighters and Fire Management Unit, should refer to applicable MOU as different hour requirements are applied.

MEL may not be used to care for a member of the employee's family. Job and/or personal stress (not the result of a diagnosed mental disorder) are specifically excluded for receipt by the employee of MEL. A statement from the employee's treating physician, subject to review by the Center for Employee Health and Wellness or medical designee is required.

An employee is not eligible for MEL if he or she is receiving Worker's Compensation benefits. An employee eligible for State Disability Insurance and/or Short Term Disability must agree to integrate these benefits with Medical Emergency Leave.

### Filing a Claim

To file a claim for MEL benefits, you must complete and submit the following forms:

- ✓ Medical Emergency Leave (MEL) Request
- ✓ Medical Emergency Leave Permission to Advertise

- ✓ Attending Physician Statement
- ✓ Leave Integration Request
- ✓ Release of Medical Information

You can obtain MEL forms from your department's payroll specialist or download the forms from the intranet at <http://countyline/emacs/forms.asp>. No MEL benefits will be paid until all completed forms have been received and approved by EBSD. MEL is not a retroactive benefit, and is paid prospectively from date of approval.

**NOTE:** Failure to furnish completed forms prior to returning to work will result in the loss of MEL benefits. For further information contact EBSD at (909) 387-5787.

## LIFE INSURANCE

Life insurance provides your beneficiaries with valuable financial protection in the event of your death.

### Basic Life Insurance

The County pays the premium for a term life insurance policy for each employee according to the provisions set forth in their applicable MOU, Exempt Compensation Plan, Salary Ordinance or Contract. If, for whatever reason, you do not maintain eligibility, you will have the option of continuing the coverage at your own expense.

Your life insurance becomes effective on the same date as your medical, dental, and vision benefits. You must designate a beneficiary at the time of enrollment. Benefits will be paid according to your instructions. If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit using the order of eligibility listed in the Certificate of Insurance provided by Minnesota Life Insurance Company.

### Supplemental Life Insurance

Eligible employees may purchase additional life insurance for themselves through the supplemental life insurance plan.

Your Age	Bi-weekly Premium Cost Per \$1,000 of Coverage
Under 30	\$0.0185
30 but less than 35	\$0.0245
35 but less than 40	\$0.0272
40 but less than 45	\$0.0305
45 but less than 50	\$0.0457
50 but less than 55	\$0.0697
55 but less than 60	\$0.1306
60 but less than 65	\$0.2012
65 but less than 70	\$0.3863
70 and over*	\$0.6272

*\* The Supplemental Life Insurance coverage amount will be reduced on the date an employee reaches 70, 75 and 80. For employees who enroll and who have already reached age 70, the reduction becomes effective on the Supplemental Life Insurance effective date. Reduction amounts are available in the Supplemental Life Insurance booklet that is available from your payroll specialist.*

## **Eligibility**

Your MOU, Exempt Compensation Plan, Salary Ordinance, or Contract governs your eligibility for Supplemental Life Insurance. All Units are eligible, except for the following:

- ✓ Per Diem Nurses
- ✓ Certain Contract Positions (please refer to your contract for eligibility)

Before you enroll in the plan or make changes to your elections during the annual Open Enrollment, you must:

- ✓ Work 41 hours or more per pay period (you are not eligible to enroll in or increase coverage if you are on a leave of absence)

You may enroll within 60 days of becoming eligible, or during the annual Open Enrollment. After your initial enrollment, you may make changes in coverage only during the annual Open Enrollment.

## **Plan Options**

If you are eligible to participate in the plan, you may choose coverage in \$10,000 increments (i.e., \$70,000, \$80,000, \$90,000, etc.) up to a maximum of \$700,000. Coverage of up to \$250,000 is guaranteed without requiring evidence of insurability. If you elect more than \$250,000 of coverage, you will be required to provide evidence of insurability to the insurance company. If you are denied coverage above \$250,000, your Supplemental Life Insurance will be limited to \$250,000.

## **Beneficiary for Supplemental Life Insurance**

If you do not designate a beneficiary, benefits will be paid automatically to your beneficiaries in the following order: (1) surviving lawful spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally. To designate a beneficiary, you must complete the Supplemental Life Insurance Beneficiary Designation/Change form through eBenefits (during the Open Enrollment period only) or through your payroll specialist at any time throughout the year.

**NOTE:** Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) must be paid on an after-tax basis per IRS regulations.

## **Payroll Deductions and Effective Date of Coverage**

Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium payment. If you have requested coverage above \$250,000, the effective date of the excessive coverage is subject to insurance company approval.

## **Waiver of Premium While Disabled**

Waiver of premium is a provision which allows for continued participation in the life insurance plan without payment of premium while you are disabled, and it is subject to insurance company approval.

Should there be insufficient funds to cover premiums, the employee will be offered another payment option.

If you return to work for the County and want to continue coverage, you must contact your payroll specialist or EBSD at (909) 387-5537 within 60 days of your return-to-work date. If your disability ends but you do not return to work for the County, you may convert the County's group plan into an individual plan under the same terms as a terminating County employee.

### ***Accelerated Benefits Option***

The Accelerated Death Benefit, or “living benefit option,” provides you with an advanced benefit if you are diagnosed with a terminal illness and have less than 12 months to live. You may be eligible for up to 100 percent of your life insurance benefits (\$1 million maximum). Upon death, the balance of the life insurance benefit, if any, will be paid to the named beneficiaries. The minimum policy face value amount to be eligible for this benefit is \$10,000. Please refer to the County’s Certificate of Insurance at [http://www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx) or <http://mybenefitsatwork> for further details.

### ***Termination of Coverage***

Your Supplemental Life Insurance coverage will terminate if:

- ✓ You cancel your coverage
- ✓ You cease to be an eligible employee
- ✓ You fail to pay your required premiums when due
- ✓ The master contract is terminated
- ✓ You are on an approved leave of absence for more than 12 months

### ***Portability or Conversion of Coverage***

When you are no longer eligible for life insurance coverage through the County’s group plan, you may be eligible to continue your coverage through the portability or conversion process. You can obtain more information on this subject by contacting EBSD at (909) 387-5537 or Minnesota Life Insurance Company at (866) 293-6047.

### ***How To Get In Touch With the Supplemental Life Insurance Plan***

For questions about plan design, claim status/payments, medical underwriting and eligibility, call Minnesota Life Insurance Company at (866) 293-6047. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5537.

## **ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)**

### ***Employee Eligibility***

Your MOU, Exempt Compensation Plan, Salary Ordinance, or Contract governs your eligibility for AD&D. All Units are eligible, except for the following:

- ✓ Fire Fighters
- ✓ Per Diem Nurses
- ✓ Safety and Safety Management (please refer to your MOU for alternate coverage information available for certain groups)
- ✓ Certain Contract Positions (please refer to your contract for eligibility)

### ***Eligible Dependents for AD&D Coverage***

- ✓ Lawful Spouse
- ✓ State-registered Domestic Partner
- ✓ Unmarried children (including legally adopted children) who are under age 19 and who are dependent upon you for support, or who are at least 19 but less than 24 who are full-time

students and dependent upon you for support. Refer to the Certificate of Insurance for complete details.

If you choose dependent coverage, all of your eligible dependents will be enrolled. You must be enrolled to enroll your dependents.

### Plan and Coverage Options

You have two coverage options and seven AD&D plans from which to choose. For benefit levels, please refer to the Group Benefit Plans at [www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx) or <http://mybenefitsatwork>.

### Coverage Options

- 1. Employee-only coverage:** Coverage will be the amount listed in the Employee column on the following Plan Options Table corresponding to the coverage level you select.
- 2. Employee plus family:** Coverage amounts will be the amounts listed in the Employee column, the Spouse or Domestic Partner column and Each Child column, as applicable to your family.

If you marry or enter into a state-registered domestic partnership after enrolling for AD&D coverage, you may add your new spouse or domestic partner by submitting new enrollment and payroll deduction authorization forms within 60 days of the date of marriage or commencement of domestic partnership. Once family coverage is in force, all newly eligible dependents (such as a newborn) are enrolled automatically.

### AD&D Plan Options Table

Plan	Employee	Spouse or Domestic Partner	Each Child
1	\$10,000	\$5,000	\$3,125
2	\$25,000	\$12,500	\$6,250
3	\$50,000	\$25,000	\$12,500
4	\$100,000	\$50,000	\$25,000
5	\$150,000	\$75,000	\$25,000
6	\$200,000	\$100,000	\$25,000
7	\$250,000	\$125,000	\$25,000

### AD&D Premium Table

Plan	Employee-Only Coverage	Employee and Family Coverage
1	\$ 0.092/pay period	\$ 0.138/pay period
2	\$ 0.230/pay period	\$ 0.345/pay period
3	\$ 0.460/pay period	\$ 0.690/pay period
4	\$ 0.920/pay period	\$ 1.38/pay period
5	\$ 1.38/pay period	\$ 2.07/pay period
6	\$ 1.84/pay period	\$ 2.76/pay period
7	\$ 2.30/pay period	\$ 3.45/pay period

### ***Beneficiary for AD&D***

If you do not designate a beneficiary, insurance benefits will be automatically paid to your beneficiaries in the following order: (1) surviving lawful spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally. To designate a beneficiary you must complete the beneficiary designation form.

### ***Payroll Deductions and Effective Date of Coverage***

Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium payment. Should there be insufficient funds to cover premiums, the employee will be offered another payment option. Before-tax payroll deductions for AD&D premiums are available. If before-tax dollars are used to pay the premiums, you may cancel the plan only when you have a qualified change-in-status/life event.

### ***Termination of Coverage***

Your AD&D coverage will terminate if:

- ✓ You cancel your coverage
- ✓ You cease to be an eligible employee
- ✓ You fail to pay your required premiums when due
- ✓ The master contract is terminated
- ✓ You are on an approved leave of absence for more than 12 months

### ***Portability Benefit***

The portability benefit provides for continuation of your group accidental death and dismemberment insurance if you no longer meet the eligibility requirements of the County's group plan. To continue coverage under this provision, you must make a written request and make the first premium payment within 60 days after the AD&D coverage ends with the County. For more information on this benefit, you can contact EBSD at (909) 387-5537.

### ***How To Get In Touch With an AD&D Representative***

For questions about plan design, claim status/payments, medical underwriting and eligibility, call Minnesota Life Insurance Company at (866) 293-6047. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5537.

## **MY HEALTH MATTERS!**

Take a step to becoming a new, healthier you with My Health Matters! (MHM!), the County's wellness program. MHM! offers a wealth of resources to help you in your journey of wellness. Whether you are making the first step towards wellness or are looking for ways to enhance your already established regimen, we encourage you to visit the MHM! web page on the intranet at <http://mybenefitsatwork> or on the internet at [http://www.sbcounty.gov/hr/Benefits\\_MyHlth.aspx](http://www.sbcounty.gov/hr/Benefits_MyHlth.aspx)

Steps to Success, the MHM! web-based activity portal, is a great way to track your physical activities, manage your calorie intake, participate in a challenge, and receive incentives along the way.

Take advantage of the variety of worksite wellness programs offered through MHM! By participating in a wellness class, you can learn tips to reduce stress, discover ways to incorporate healthy food choices in your diet, and much more!

## Biometric Screenings & Health Risk Assessment

Biometric Screenings and Health Risk Assessments are two major components of the My Health Matters! Wellness Program.

### ***What is a biometric health screening and why is it important?***

A biometric health screening is a short health examination that indicates your risk for certain diseases and medical conditions. It helps you understand where you should take action to improve your health. The following screenings are included:

- ✓ **Body Mass Index (BMI)** – Maintaining a BMI within the healthy range can reduce blood pressure, cholesterol, blood glucose and lower your risk for heart disease, stroke, cancer, diabetes, and kidney disease.
- ✓ **Blood Pressure (BP)** – Healthy blood pressure is key to heart health. BP within the healthy/normal range, can be achieved or maintained by adopting a healthy lifestyle and can prevent or delay the onset of high blood pressure or other health problems.
- ✓ **Cholesterol** – Bad/high cholesterol can lead to heart disease or increased potential for experiencing a heart attack.
- ✓ **Glucose** – High glucose levels cause many of the health problems associated with diabetes.

### ***What is a Health Risk Assessment and why is it important?***

A health risk assessment (HRA) is a health questionnaire used to provide individuals with an evaluation of their health risks and lifestyle. Having an understanding of your health risks means that you can take the necessary steps to improve your health and prevent or maintain chronic conditions.

## Smoking Cessation

If you are ready to quit smoking, My Health Matters! is here to help. As a subscriber in the County-sponsored Kaiser or Blue Shield medical plans, you can take advantage of the smoking cessation resources offered and start your journey to being smoke free! Please visit the My Health Matters web pages for more information: [http://www.sbcounty.gov/hr/Benefits\\_MyHlth.aspx](http://www.sbcounty.gov/hr/Benefits_MyHlth.aspx)

Start making healthier choices today! For more information regarding MHM!

- ✓ Visit <http://mybenefitsatwork> or [http://www.sbcounty.gov/hr/Benefits\\_MyHlth.aspx](http://www.sbcounty.gov/hr/Benefits_MyHlth.aspx)
- ✓ Call your Department Wellness Advocate. View the directory posted on the MHM! webpage
- ✓ Contact EBSD staff via email at [mhm@hr.sbcounty.gov](mailto:mhm@hr.sbcounty.gov) or via phone at (909) 387-5787



## HEALTH CLUB MEMBERSHIP

County employees, retirees or their family members are eligible for discounted gym memberships through both LA Fitness and 24 Hour Fitness.

This program is part of the County's commitment to help you stay well and maintain a healthier lifestyle. County employees who already have a non-County membership at LA Fitness or 24 Hour Fitness are eligible to have monthly dues reduced to the County rate.

### LA Fitness

Employees may enroll at any LA Fitness club location after receiving a promotional code (e-voucher) from the EBSD for a membership valid at all LA Fitness clubs, except Signature Clubs. To request a discount, email MyHealthMatters! at [mhm@hr.sbcounty.gov](mailto:mhm@hr.sbcounty.gov). LA Fitness provides discounted monthly membership dues of \$29.99 with no initiation fee. Racquetball court usage may be added at an additional amount of \$5 per month.

Upon initial enrollment, employees will be responsible for immediate payment of first and last months' dues. Monthly dues are paid thereafter by pre-authorized direct debit or credit card payment. Payroll deduction is not available. Please note that employees may cancel their LA Fitness membership at any time without penalty.

	Initiation and Processing Fee	Monthly Fee for One Club Access
Employee-Only	\$0	\$29.99
Each Additional Member	\$0	\$29.99

### 24 Hour Fitness

Employees may enroll at any 24 Hour Fitness Club by bringing an employee ID, business card or current paystub as proof of employment. Employees may also enroll online at [www.24hourfitness.com/corporate](http://www.24hourfitness.com/corporate) and enter ID: 14418CORP.

Upon initial enrollment, employees will be responsible for immediate payment of first and last months' dues.

	All-Club Sport Access	All-Club Super Sport Access	All-Club Ultra Sport Access
Employee Only	\$19.99 initiation fee, \$29.99 dues/month	\$29.99 initiation fee, \$38.99 dues/month	\$39.99 initiation fee, \$49.99 dues/month
Each Additional Member	\$19.99 initiation fee, \$29.99 dues/month	\$29.99 initiation fee, \$38.99 dues/month	\$39.99 initiation fee, \$49.99 dues/month

Additional discounts for gym memberships are offered as part of your medical and/or dental coverage. Check your carrier's website for details.



## RETIREMENT PLAN HIGHLIGHTS

### Eligibility

All County employees working at least 40 hours per pay period in a retirement-eligible position are automatically members of the San Bernardino County Employees' Retirement Association (SBCERA). As a member of SBCERA, you pay contributions through payroll deductions each pay period based on your membership classification and tier (i.e. General vs. Safety, and Tier 1 vs. Tier 2).

### SBCERA Membership Classifications & Tiers

SBCERA administers benefits for two membership classifications, Safety and General, and two tiers, Tier 1 and Tier 2. Safety members are those employed in active law enforcement or active fire suppression. All other members are classified as General members.

**Tier 1 members** are those with an SBCERA membership date **prior to January 1, 2013**.

**Tier 2 members** are those with an SBCERA membership date **on or after January 1, 2013**.

Below is a breakdown of the benefit formulas administered by SBCERA for each membership classification and tier:

<b>Tier 1</b>	General Members – 2% @ 55 Safety Members – 3% @ 50
<b>Tier 2</b>	General Members – 2.5% @ 67 Safety Members – 2.7% @ 57

### SBCERA Contribution Rates

Member contribution rates are set annually. Changes to the rates are determined by financial studies conducted by independent actuaries. The Board of Retirement reviews and sets contribution rate increases or decreases on the basis of these studies each fiscal year. **This year, effective June 27, 2015, your contribution rate may or may not change.** Some rates for Tier 1 General and Safety Members increased slightly, while some rates stayed the same. Tier 2 rates increased to 8.40% for General Members and 15.22% for Safety Members.

The following contribution rate tables detail the latest refundable and non-refundable rates for General Tier 1 Members and Safety Tier 1 Members. General Tier 2 Members will pay 8.40% and Safety Tier 2 Members will pay 15.22%.

## Tier 1 Member Retirement Contribution Rate Table

Tier 1 General Members Contribution Rate (%) Effective June 27, 2015			Tier 1 Safety Employees Contribution Rate (%) Effective June 27, 2015		
Entry Age	Refundable	Non-Refundable	Entry Age	Refundable	Non-Refundable
16	8.44	7.81	16	10.94	10.62
17	8.58	7.94	17	11.12	10.80
18	8.71	8.06	18	11.32	10.99
19	8.86	8.20	19	11.50	11.17
20	9.00	8.33	20	11.70	11.36
21	9.15	8.47	21	11.89	11.54
22	9.30	8.61	22	12.10	11.75
23	9.44	8.74	23	12.31	11.95
24	9.61	8.90	24	12.53	12.17
25	9.76	9.04	25	12.74	12.37
26	9.92	9.19	26	12.96	12.58
27	10.08	9.33	27	13.20	12.82
28	10.25	9.49	28	13.42	13.03
29	10.41	9.64	29	13.66	13.26
30	10.59	9.81	30	13.92	13.51
31	10.76	9.96	31	14.16	13.75
32	10.93	10.12	32	14.41	13.99
33	11.12	10.30	33	14.65	14.22
34	11.31	10.47	34	14.90	14.47
35	11.49	10.64	35	15.15	14.71
36	11.69	10.82	36	15.42	14.97
37	11.90	11.02	37	15.69	15.23
38	12.10	11.20	38	15.95	15.49
39	12.33	11.42	39	16.22	15.75
40	12.55	11.62	40	16.50	16.02
41	12.78	11.83	41	16.77	16.28
42	13.02	12.06	42	16.95	16.46
43	13.26	12.28	43	17.08	16.58
44	13.50	12.50	44	17.19	16.69
45	13.75	12.73	45	17.30	16.80
46	14.00	12.96	46	17.42	16.91
47	14.24	13.19	47	17.57	17.06
48	14.44	13.37	48	17.35	16.84
49	14.57	13.49	49 & Over	16.87	16.38
50	14.67	13.58	Effective June 28 <sup>th</sup> for all General Members, the Survivors' Benefit Contribution will decrease from \$1.85 to \$1.72 per pay period.		
51	14.76	13.67			
52	14.85	13.75			
53	14.61	13.53			
54 & Over	14.21	13.16			

## Tier 2 Member Retirement Contribution Rate Table

Tier 2 General Members Contribution Rate (%)	Tier 2 Safety Employees Contribution Rate (%)
Refundable Fixed Flat Rate: 8.40%	Refundable Fixed Flat Rate: 15.22%
Non-refundable Fixed Flat Rate: 7.70%	Non-refundable Fixed Flat Rate: 14.70%

*These contribution rate tables summarize the information provided by SBCERA. In the event of any discrepancy between this information and the California Government Code, SBCERA By-Laws, and SBCERA policies, the Code provisions, By-Laws, and policies will govern. For Tier 2 members, the non-refundable rate was only available if your MOU provided for it on January 1, 2013. Once that MOU expires or is amended in any way, including an extension, the non-refundable rate is no longer available.*

## Refundable and Non-refundable Retirement Options

You may be able to change your retirement contribution option during Open Enrollment if it is permitted by your MOU. If you wish to change your retirement option, you must complete the Retirement System Contribution Election section of eBenefits. Elections will be effective pay period 17 and you will see the election change on the pay warrant you receive on or about August 19, 2015.

### **Refundable Retirement Contributions**

If you designate your retirement contributions as refundable, then you pay the regular contribution rate required to meet your retirement obligation. If you leave employment without retiring, you may withdraw or rollover these refundable contributions plus earned interest in one lump-sum payment from SBCERA.

### **Non-refundable Retirement Contributions**

For Tier 2 members, the non-refundable rate was only available if your MOU provided for it on January 1, 2013. Once that MOU expires or is amended in any way, including an extension, the non-refundable rate is no longer available. If you designate your retirement contributions as non-refundable, you pay a reduced contribution rate. This reduction is determined by the Board of Retirement annually and is subject to change. If you leave employment without retiring, you may not withdraw or rollover these non-refundable contributions from SBCERA.

**Refundable vs. Non-refundable Table**

The following table outlines the refundable and non-refundable retirement options. Additional options may apply if you terminate employment and are re-employed by another public agency in California within 180 days of your termination.

EVENT	REFUNDABLE OPTION	NON-REFUNDABLE OPTION
Employee's bi-weekly cost	See contribution rate tables above.	See contribution rate tables above.
LESS THAN FIVE (5) YEARS OF SERVICE CREDIT		
Termination	You may refund or rollover all of your refundable contributions plus applicable interest in a lump-sum payment; or, you may choose to leave your contributions "on deposit" with SBCERA where it will continue to earn the applicable member deposit interest rate until such time that you choose to rollover or refund.	You cannot refund or rollover any non-refundable contributions. If you made contributions under both the refundable and non-refundable options, only the refundable contributions can be refunded or rolled over.
Selecting a refund of your contributions will end your membership with SBCERA and terminate any future claims for retirement benefits, including disability benefits.		
Non service-related death	<b>Lump-Sum Payment:</b> Your spouse, registered domestic partner, eligible child and/or other named beneficiary may receive one month's compensation for each completed year of service credit up to a maximum of six months' compensation. <b>Refundable Option:</b> Compensation as outlined above plus a lump-sum payment of your refundable contributions and interest may be paid to an eligible beneficiary.	<b>Non-refundable contributions will not be refunded.</b> If you made contributions under both the refundable and non-refundable options, only the refundable contributions and applicable interest may be paid to your eligible beneficiary.
FIVE (5) OR MORE YEARS OF SERVICE CREDIT		
Termination	You may choose to defer retirement <b>OR</b> receive a lump-sum payment of all refundable contributions and interest in your retirement account.	You may choose a deferred retirement. Your non-refundable contributions cannot be refunded. If you made contributions under both the refundable and non-refundable options, only the refundable contributions can be refunded or rolled over.
Selecting a refund of your contributions will end your membership with SBCERA and terminate any future claims for retirement benefits, including disability benefits.		

<p><b>Non service-related death</b></p> <p><i>Your beneficiary or beneficiaries may be able choose between each of the following options:</i></p>	<p><b>1. Optional Death Allowance:</b> Your eligible spouse, registered domestic partner or eligible child will receive a monthly payment equal to 60% of the amount awarded in a non service-connected disability retirement or a service retirement (if eligible at the time of your death), whichever is greater.</p> <p><b>2. Modified Optional Death Allowance:</b> Your eligible spouse or registered domestic partner will receive a lump-sum payment of one month's compensation for each completed year of service credit up to a maximum of six months' compensation; plus a reduced monthly benefit depending on the age of the beneficiary.</p> <p><b>3. Lump-Sum Payment:</b> Your spouse, registered domestic partner, eligible child and/or other named beneficiary will receive one month's compensation for each completed year of service credit up to a maximum of six months' compensation.</p> <div> <p><b>Refundable Option:</b> Compensation as outlined above plus a lump-sum payment of your refundable contributions and applicable interest may be paid to an eligible beneficiary.</p> <p><b>Non-refundable contributions will not be refunded.</b> If you made contributions under both the refundable and non-refundable options, only the refundable contributions and applicable interest may be paid to your eligible beneficiary.</p> </div>
<b>SURVIVOR BENEFIT</b>	
<p><b>General Member death after 18 months of continuous SBCERA membership</b></p>	<p>Your spouse, registered domestic partner or dependent children may also be entitled to an additional monthly survivor benefit amount</p>

Additional benefits apply in retirement. Please consult your SBCERA Summary Plan Description, "The Compass" for complete details.

## 457(b) DEFERRED COMPENSATION PLAN

The 457(b) is a supplemental retirement Plan that allows employees to contribute a portion of their pre-tax (Traditional) or after-tax (Roth) salary, within certain Internal Revenue Service (IRS) limits, to a personal account currently maintained by Voya Financial. Employees may select from multiple mutual funds and a stable value account when investing their funds. The County, as Plan Administrator, regularly monitors the investment options and deletes or replaces funds that fail to perform according to the guidelines set forth in the *County of San Bernardino Defined Contribution Plans and Retirement Medical Trust Plan Investment Policy Statement*.

Reminder: To receive a County match, you must be eligible, enrolled in, and contributing to a 457(b) Plan.

### Eligibility

All general employees in regular positions, and other employees that are granted this benefit through an employment contract or Exempt Compensation plan, are eligible to participate in the County's 457(b) Deferred Compensation Plan and can enroll at any time. In addition, certain bargaining units have added a County match if the employee is participating in the 457(b) Plan. Check your MOU to determine if you are eligible for this benefit. If you are eligible for the County match, all County contributions will be deferred to a 401(a) Defined Contribution Plan. The current investment provider is Voya Financial.

### Contributions

Contributions to the 457 may be deposited on a Pre-Tax basis (Traditional 457) or on an After-Tax basis (Roth 457). Participants can select either option or both for their contributions.

- ✓ For the Traditional 457 option, contributions and any earnings that accumulate are not taxed until the funds are withdrawn.
- ✓ For the Roth 457 option, contributions and any earnings that accumulate can be withdrawn tax-free in retirement if the requirements for a "qualified distribution" are met.

The IRS does impose restrictions on when these funds can be accessed. Upon complete separation from County service, participants may choose to withdraw a portion or all of their 457(b) account balance. Federal and state taxes may apply on the amount withdrawn from Traditional 457 or Roth 457 if the Roth distribution does not meet qualified distribution criteria. To be a qualified tax-free distribution from Roth 457, you must have had the Roth 457 account for a minimum of 5 years AND experience one of these events:

- ✓ Attainment of age 59½
- ✓ Disability
- ✓ Death
- ✓ Certain first-time home purchases

Unlike with most 401(k) plans, there is no penalty for withdrawals made from a 457(b) Plan prior to the participant's attainment of age 59½.

### In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship provisions in the 457(b) Plan document before participating in the plan.

Any employee who has questions, or who is interested in participating in the 457(b) Plan, should contact the local Voya Financial office at (909) 748-6468 to schedule an appointment. This benefit does not have an Open Enrollment period so employees can enroll at any time.

For more extensive information on the County's 457(b) Plan and Voya Financial, please visit the County's custom Voya Financial website at [www.cosb.beready2retire.com](http://www.cosb.beready2retire.com)

## 401(k) DEFINED CONTRIBUTION PLAN

Traditional 401(k): Allows participating employees to reduce their taxable income by contributing a portion of their gross income to the 401(k) on a pre-tax basis. Contributions and earnings are not taxed until they are withdrawn, generally at retirement when participants are usually in a lower tax bracket.

Roth 401(k): Allows participating employees the opportunity to take tax-free distributions upon retirement, as long as the participant meets certain qualifications, by paying taxes on their contributions up front. Unlike the Traditional 401(k), the Roth 401(k) offers the participant the potential for tax-free retirement income later by investing on an after-tax basis now.

### Eligibility

Exempt employees, Elected Officials and other employees that are granted this benefit through an employment contract are eligible to participate in this supplemental retirement plan that allows employees to defer a portion of their salary on a pre-tax (Traditional) or after-tax (Roth) basis, within certain IRS limits, to an account maintained by an investment service provider. The current investment provider is Voya Financial.

Employees may enroll at any time and may select from multiple investment options including a stable value account when investing their funds.

In addition to the employee's contribution, the County will match up to 4% of the participant's salary at a ratio of 2 to 1 for employees in Exempt Group A, B, and C. The County will match up to 3% of the participant's salary at a ratio of 2 to 1 for employees in Exempt Group D. For example, if a participant in group A, B, or C elects to defer 4% or more of their bi-weekly base salary to the Plan, the County will contribute a maximum of 4% times two for a total of 8% of the bi-weekly base salary. However, if the participant elects to defer less than 4% of their bi-weekly base salary then the County will only match the elected percentage times two.

### Withdrawal Period

The IRS imposes restrictions on when these funds can be accessed. There is a substantial early withdrawal penalty that will be assessed against any distributions made prior to age 59½ (or age 55 if eligible to retire under SBCERA at that age).

### In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship provisions in the 401(k) Plan document before participating in the plan.

Any employee who has questions, or who is interested in participating in the 401(k) Plan, should contact the local Voya Financial office at (909) 748-6468 to schedule an appointment. This benefit does not have an Open Enrollment period so employees can enroll at any time.

For more extensive information on the County's 401(k) Plan and Voya Financial, please visit the County's custom Voya Financial website at [www.cosb.beready2retire.com](http://www.cosb.beready2retire.com)

## RETIREMENT MEDICAL TRUST FUND

The Retirement Medical Trust (RMT) Fund Plan was implemented by the County of San Bernardino to assist eligible retirees and their dependents with the high cost of health related expenses. It provides a method for eligible participants to pay, on a nontaxable basis, for qualified expenses including medical, dental, and long-term care premiums (as defined in IRC Section 213) that are not otherwise reimbursed by insurance.

The Trust is funded by the eligible cash value of the participant's sick leave upon separation from service and/or County Contributions.

***Sick Leave Conversion to RMT*** - Eligible employees may convert a portion of their sick leave, based on cash value, to the RMT. Eligibility is based on a specified number of years of service as follows:

**County Exempt, Special Districts/County Fire Exempt** – 5 Years

**All other units/groups** – 10 Years

Service credit and/or participation in other public sector retirement systems may also be counted towards the service requirement, provided that the employee has not withdrawn their contributions from the system(s) and the employee is also a participant in SBCERA.

***County Contributions*** - The County contributes to the RMT, on behalf of employees, on a percentage basis of an employee's base bi-weekly salary. The percentage amount and qualifying years of service varies by MOU, Compensation plan, Salary Ordinance, or Employment contract. Please refer to the applicable document for the contribution amount. For all units/groups, except County Exempt and Special Districts/County Fire Exempt, Other Public Service credit does not count towards the years of service to receive the County contribution.

All funds contributed to the Trust are maintained in individual accounts administered by Voya Financial exclusively for the benefit of the participant or the participant's eligible dependent(s). Upon reaching the Normal Retirement Age under the Plan, the account balance is available for the reimbursement. Please refer to your MOU, Employment Contract, Salary Ordinance or Exempt Compensation Plan for specific information on participation eligibility, cash conversion formulas or unused sick leave accruals and County contributions.

For any questions or additional information regarding the Retirement Medical Trust Fund, contact EBSD at (909) 387-5537, or go online to [http://www.sbcounty.gov/hr/BenPlan\\_retmed.aspx](http://www.sbcounty.gov/hr/BenPlan_retmed.aspx) or [http://countyline/hr/benefits/mywealth/retirement\\_medical\\_trust\\_fund/home.asp](http://countyline/hr/benefits/mywealth/retirement_medical_trust_fund/home.asp). Account balances and participant information, as applicable, can be found on the Genesis website at <http://voyacdn.com/hra/genesis>

## 529 EDUCATION SAVINGS PLAN

A 529 Education Savings Plan is offered by Fidelity Investments. This plan offers all County employees a way to invest in their children's and grandchildren's education. The minimum bi-weekly deferral is \$25 and is deducted on an after-tax basis. You must contact Voya Financial to participate in the plan.

### ***Potential Tax Advantages***

This plan offers tax-deferred growth of any earnings and tax-free withdrawals for qualified higher education expenses such as room, board, and tuition.

### ***Control and Flexibility***

The owner of a 529 plan controls the assets in the account, even after the beneficiary turns 18. There are no income restrictions and account assets can be used at most accredited colleges and universities.



## ***Additional Advantages***

The advantages to the Fidelity 529 Education Savings Plan are its:

- ✓ Ability to accept bi-weekly payroll deductions
- ✓ Low investment management fees
- ✓ Low annual account fees
- ✓ Quality and quantity of investment options

For more information or to schedule an appointment with a Voya Financial representative, contact the local Voya Financial office at (909) 748-6468. This benefit does not have an Open Enrollment period, so employees can enroll at any time.

## **COMMUTER SERVICES**

Human Resources – Commuter Services (HR-CS) administers the County's Rideshare Program and assists employees with finding alternatives to driving to work alone. HR-CS offers a variety of programs including: vanpool, carpool, hybrid vehicle carpool, transit bus pass, walk and bike to work. HR-CS can help you:

- ✓ Join or form a vanpool or carpool
- ✓ Obtain information about public transportation options
- ✓ Take advantage of tax benefits such as pre-tax payroll deductions for vanpool rates and transit pass purchases
- ✓ Register and submit a RideMatch Request for a list of potential carpool partners, who share a similar commute and schedule – and are interested in sharing the ride
- ✓ Find information on topics pertaining to improving air quality, reducing traffic congestion, and saving money through newsletters, payroll stuffers, and e-mails
- ✓ Save money and reduce your carbon footprint

Examples of incentives and rewards include:

- ✓ \$4 Per Day Start Up Incentive – Eligible ridesharing employees can receive \$4 per day for the first three months of participation in any of the County's Rideshare Programs
- ✓ Membership in the Rideshare Plus Rewards Club provides discounts to more than 135,000 merchants in the Inland Empire and in the United States
- ✓ Earn gas cards or Big 5 gift cards every six months for participation
- ✓ Monthly drawings for \$25 gift cards for employees who track rideshare participation with HR-CS each month
- ✓ Invitation to the Annual Commuter Services Rideshare luncheon

HR-CS sponsors Brown Bag Luncheon events at locations across the county. Attendees learn about various rideshare programs, incentives for participating, environmentally friendly tips for work and home and much more.

Visit the HR – CS Intranet site at <http://countyline.sbcounty.gov/commuterservices/> to learn more about different rideshare options and for information on how participating in the County's rideshare program can benefit you. You can reach HR-CS at (909) 387-9640 or (909) 387-9639.

## **SICK LEAVE CONVERSION**

Employees in certain bargaining units who have used less than forty (40) hours of sick leave in a fiscal year may, at the employee's option, convert sick leave to vacation by the following formula: Hours of sick leave used are subtracted from forty (40). Sixty percent (60%) of the remainder, or a portion thereof, may be added to vacation leave to be utilized in the same manner as other accrued vacation leave. This benefit only applies to certain bargaining units. Check your MOU for details and to determine if you are eligible for this benefit.

## **VACATION/HOLIDAY CASH-OUT**

An employee may sell back vacation or holiday time at the base hourly rate of the employee as hereinafter provided, upon approval of the appointing authority. Eligible employees may exercise this option under procedures established by the Director of Human Resources or designee. In lieu of cash, the employee may designate that part or all of the value of vacation time to be sold back is allocated to a deferred income plan if the County approves such a plan and credit for vacation time is allowed under the plan. This benefit only applies to certain bargaining units. Check your MOU for details and to determine if you are eligible for this benefit.

## **UNEMPLOYMENT INSURANCE**

The Unemployment Insurance Program, commonly referred to as UI, provides weekly unemployment insurance payments for workers who lose their jobs through no fault of their own. Eligibility for benefits requires that the claimant be able to work, be seeking work, and be willing to accept a suitable job. Employees do not pay for this benefit, it is financed by employers.

There are several ways to file a claim:

1. File using the online application at [www.edd.ca.gov](http://www.edd.ca.gov)
2. File by telephone using the toll-free number to contact the call center at (800) 300-5616 between 8:00 a.m. – 12 noon., Monday through Friday
3. File a UI Application by mail or fax, accessing the application on-line at <http://www.edd.ca.gov/Unemployment>. An application for UI can be filled out on-line and printed, or printed and completed by hand. Mail or fax your UI application using the address listed on the application.

## **YOUR MEDICAL AND DENTAL BENEFITS UPON RETIREMENT**

When you retire from the County of San Bernardino, you are eligible to participate in the County-sponsored medical and dental plans. As a retiree, you are responsible for paying 100% of the cost of premiums. At the time you meet with a Retirement Specialist at SBCERA, you will be provided with EBSD's contact information for making an appointment to discuss your medical and dental enrollment options. Contact us at [ebd@hr.sbcounty.gov](mailto:ebd@hr.sbcounty.gov) with questions.

## APPEAL PROCEDURE

### General Information

In the event an employee or beneficiary believes that a request or claim for a benefit under a health and welfare, flexible spending account, or salary savings plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the County's benefit carriers must be submitted within the guidelines established by that carrier. EBSD, if requested to do so, will act as an advocate and will assist to ensure that the appeal receives due consideration.

### Timeframes

Any employee or beneficiary whose request or claim for benefits is denied has the right to request a review by filing an appeal in writing directly with the EBSD Appeals Unit. Appeals must be submitted within 30 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as any supporting documentation. Within 15 calendar days of the date the appeal is received, the EBSD Appeals Unit will review the facts and respond in writing with its findings. Should special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 15 days. The EBSD Appeals Unit will provide written notification if an extension is needed.

If the appeal does not contain sufficient information to make a decision, an extension may be granted to obtain such information. The appellant will be notified in writing of the extension which will specifically describe the required information and will be afforded 15 calendar days from the date of the notice to provide the specified information.

Upon timely delivery of the requested information, and within 15 calendar days, the EBSD Appeals Unit must report its findings. Should the requested information not be received by EBSD within the time specified, the EBSD Appeals Unit will make a decision without it, in which case, the decision is final and is not eligible for a second appeal.

**FSA Appeals for Denied Claims:** FSA participants have 60 days from the date a claim denial is mailed to participant to submit a written appeal for review, and the EBSD Appeals Unit has 60 days from the date the appeal is received to provide a final decision. Please refer to the FSA Plan document for more information about the plan and its appeal process.

### Notification

**Note:** All approvals are subject to carrier contract limitations.

Notice of the appeal decision will include the following:

1. The EBSD Appeal Unit's decision;
2. The specific reason(s) for the appeal determination;
3. A reference to the specific Plan provision(s) on which the determination is based;
4. A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on when adverse determination has been made;
5. With the exception of appeals processed without the necessary information as described above, a statement outlining the second appeal process will be included in the letter. If the appellant disagrees with the EBSD Appeal Unit's decision and there is additional information that was not included in the first appeal which supports the position, a second appeal can be made to the attention of the EBSD Benefits Chief, whose decision will be final. Such appeals must be received within 15 calendar days of the first appeal decision notice.

Please contact EBSD with questions or concerns about the Appeals Process by calling (909) 387-5787.

### ***Patient Protection and Affordable Care Act (PPACA): Health Plan Eligibility***

The PPACA mandates that full-time employees be offered affordable medical Insurance.

In general, full-time employees are defined as those working, on average, at least 30 hours per week (or 130 hours in a calendar month). As defined by the PPACA, coverage is considered affordable if the employee's share of the annual premium for the lowest priced employee-only plan is no greater than 9.56% of the annual household income.

The County of San Bernardino requires employees covered by a Memorandum of Understanding (MOU), Exempt Compensation Plan, or Salary Ordinance to be enrolled in a group-sponsored medical and/or dental plan. Certain employees are not required to be enrolled in a medical and/or dental plan and are considered to be 'contingent employees'. Contingent employees are those that are not covered by a MOU or required by an employment contract to be enrolled in a medical and/or dental plan.

Contingent employees include (but are not limited to):

- Recurrent employees
- Public Service employees (PSE)
- Per diem employees
- Paid Work Experience employees (WEX)
- Returning retired employees

The County offers an unsubsidized, minimum essential value plan (Bronze level) for contingent employees. Eligible dependents may also be enrolled in this plan. Information about the Bronze Plan can be found on our webpages at:

<http://www.sbcounty.gov/hr/BlueShieldPPOBronzePlan.aspx>

### ***Health Plan Eligibility Measurement***

Effective May 2015, the County will use a look-back measurement method to determine who is a full-time employee for purposes of plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for plan coverage determinations.

The look-back measurement method applies to all employees and it involves three different periods:

- A **measurement period** for counting your hours of service to determine eligibility for medical insurance during the stability period. Your hours of service during the measurement period will determine whether you have full-time status and are eligible for coverage.

- If you are an ongoing employee, this measurement period (which is also called the “standard measurement period”) runs from pay period 11 of each year and ends pay period 10 of the following year. This measurement will determine your plan eligibility for the stability period that follows the measurement period. For example, in 2015, the measurement period begins May 2, 2015 and runs through April 29, 2016.
- If you are a new contingent employee with variable hours, the measurement period will begin on your date of hire and will last through pay period 10 following your date of hire. For example, if hired on June 1, 2015, the measurement period begins June 1, 2015 and runs through April 29, 2016.
- If you are a new contingent employee who is expected to work full time, the County is required to offer you medical insurance within the first 90 days of employment.
- A **stability period** follows the measurement period. For example, in 2015, the stability period begins July 25, 2015 and runs through July 22, 2016. As a general rule, your status as a full-time employee or a non-full-time employee is ‘locked in’ for the stability period, regardless of how many hours you work during this timeframe, as long as you remain an employee of the County. There are exceptions to this general rule for employees who experience certain changes in employment status, such as returning from an unpaid leave of absence. The stability period begins with pay period 17 and runs through pay period 16 of the following year.
- An **administrative period** is a short period between the measurement period and the stability period when the County performs administrative tasks, such as determining eligibility for coverage and facilitating plan enrollment. The administrative period begins with pay period 11 and runs through pay period 16. For example, in 2015, the administrative period begins May 2, 2015 and runs through July 24, 2015.

The rules for the look-back measurement method are very complex. Keep in mind that this is just a general overview of how the rules work. More complex rules may apply to your situation. The County intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Employee Benefits and Services Division at 909.387.5787.

## Patient Protection and Affordable Care Act (PPACA)

~ Required Notices ~

### Grandfathered Health Plans

The County of San Bernardino believes all of its medical insurance plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Human Resources-Employee Benefits and Services.

### The Women’s Health and Cancer Rights Act (WHCRA) of 1998 Annual Notice

As required by the Women’s Health and Cancer Rights Act (WHRA) of 1998, the medical plans provide coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

***For more information regarding the above notices, contact the plan administrator, Human Resources-Employee Benefits and Services at (909) 387-5787.***



## COUNTY OF SAN BERNARDINO

### Medical Expense Reimbursement Plans

### NOTICE OF PRIVACY PRACTICES

**Effective Date of Notice: June 28, 2013**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by the plan – whether received in writing, in an electronic medium, or as oral communication. This notice describes the privacy practices of the County of San Bernardino's Medical Expense Reimbursement Plan(s). The plans covered by this notice may share health information with each other to carry out Treatment, Payment or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

#### **The Plan's duties with respect to health information about you**

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information.

#### **How the Plan(s) may use or disclose your health information**

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment Activities, and/or Health Care Operations. Here are some examples of what this might entail:

- **Treatment**. While the Plan generally does not use or disclose your PHI to health care providers for treatment, the Plan is permitted to do so if necessary.
- **Payment**. The Plan may use or disclose your PHI to administer the Plan, which includes reimbursing you for eligible health care expenses for you and your dependents that are not reimbursed by insurance. The Plan may use your information to determine your eligibility for enrollment and for reimbursement and other services, including responding to complaints, appeals and external review requests.
- **Health Plan Operations**. For example, the Plan may use or disclose your PHI to perform its functions as a flexible spending account (FSA) plan. This may include: quality assessment and improvement activities, internal grievance resolution, fraud and abuse compliance programs, authorizing business associates to perform data aggregation services; and managing, planning or developing the Plan's business including conducting or arranging for legal, billing, auditing, compliance and other administrative support functions and/or services.
- **To Business Associates**. The Plan may disclose your PHI to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. The Plan will not use or disclose PHI that is your genetic information. The Plan may also contact you to provide you with information about other flexible spending account benefits and services that may be of interest to you.

#### **How the Plan may share your health information with the County of San Bernardino**

The Plan may disclose your health information without your written authorization to The County of San Bernardino for plan administration purposes. The County of San Bernardino may need your health information to administer benefits under the Plan. The County of San Bernardino agrees not to use or disclose your health



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information other than as permitted or required by the Plan document and by law. The staff of the Human Resources Department, Employee Benefits and Services Division (EBSD) are the only County employees who will have access to your health information for plan administration functions.

Please be aware that The County of San Bernardino cannot and will not use health information obtained from the Plan for any employment-related actions.

**Other allowable uses or disclosures of your health information**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' Compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonable able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonable believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public Health activities	Disclosures authorized by law to person who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you would not put you at further risk).
Judicial and Administrative Proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
Law Enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. The Plan will never sell your



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health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

**Your individual rights**

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

- **Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse.** You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

- **Right to receive confidential communications of your health information.** If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

- **Right to inspect and copy your health information.** With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

1. The access or copies you requested;
2. A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
3. A written statement that the time period for reviewing your request will be extended by no more than 30 days, along with the reasons for the delay and the date by which the Plan expects to address your request.



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You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

- **Right to amend your health information that is inaccurate or incomplete.** With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g. information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

1. Make the amendment as requested;
2. Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
3. Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

- **Right to receive an accounting of disclosure of your health information.** You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six (6) years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

1. For Treatment, Payment or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. To family members or friends involved in your care (where disclosure is permitted without authorization);
6. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstance; or
7. As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which



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the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

- **Right to obtain a paper copy of this notice from the Plan upon request.** You have the right obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

**Changes to the information in this notice**

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on August 1, 2009. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice either electronically or by mail to your mailing address. If you receive this Notice electronically, you may also request a paper copy at no charge. This Notice is also posted on the County of San Bernardino, Human Resources Department website ([http://www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx)).

**Our right to check your identity**

For your protection, we may check your identity whenever you have questions about your specific enrollment Plan activities. We will check your identity whenever you submit requests to look at, copy or amend your records or to obtain a list of disclosures of your health information.

**Complaints**

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan or to the County of San Bernardino, Office of Compliance and Ethics at the addresses listed below. Alternatively you may complain to the Secretary of the U.S. Department of Health and Human Services, at the regional office that handles your area, generally within 180 days of when the act or omission occurred. You will not be retaliated against for filing a complaint.

<p>To file a complaint with the Plan as administered by the County Human Resources Department, contact:</p> <p>Benefits Chief, Department of Human Resources Employee Benefits and Services 157 W. Fifth Street, First Floor San Bernardino, CA 92415-0440</p> <p>Phone # (909) 387-5787 Fax # (909) 387-5566 Email: <a href="mailto:ebbsd@hr.sbcounty.gov">ebbsd@hr.sbcounty.gov</a></p>	<p>To file a complaint with the County of San Bernardino, Office of Compliance and Ethics:</p> <p>HIPAA Complaints Official 157 W. Fifth Street, First Floor San Bernardino, CA 92415-0440</p> <p>Phone # (909) 387-4500 Fax # (909) 387-8950 Email: <a href="mailto:HIPAAComplaints@cao.sbcounty.gov">HIPAAComplaints@cao.sbcounty.gov</a></p>
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For more information on the Plan's privacy policies or your rights under HIPAA, contact:

HIPAA Benefits Analyst  
County of San Bernardino, Human Resources Department  
Employee Benefits and Services  
157 W. Fifth Street, First Floor  
San Bernardino, CA 92415-0440

Phone # (909) 387-5787  
Fax # (909) 387-5566

**Plans that will follow this Notice include the following:**

- County of San Bernardino, Medical Expense Reimbursement Plan (Active and COBRA)
- County of San Bernardino, Exempt Medical Expense Reimbursement Plan (Active and COBRA)



**COUNTY OF SAN BERNARDINO**  
**Active Employees Self-Funded Dental PPO Plans**  
**Administered by Cigna Dental**

**NOTICE OF PRIVACY PRACTICES**

Effective Date of Notice: July 27, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by the plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the County of San Bernardino's Active Employee's Self-Funded Dental PPO Plans. Connecticut General (CG), hereby referred to as Cigna Dental is the Dental Plan Third Party Administrator. The plans covered by this notice may share health information with each other to carry out Treatment, Payment or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

**The Plan's duties with respect to health information about you**

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices. Your PHI is maintained by the business associate (Cigna Dental) that serves as the third party administrator for the Plan in which you participate, but the County may also hold health-related information. Generally, County-held information is limited to enrollment data, but in limited instances it may include information you provide to designated County staff to help with coordination of benefits or resolving complaints.

**How the Plan(s) may use or disclose your health information**

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment Activities, and/or Health Care Operations. Here are some examples of what this might entail:

- **Treatment.** Although the County does not provide direct treatment to you, your Cigna dentist and their staff may use health information about you to provide you with dental treatment or services, to include consultations and referrals. They may disclose health information about you to dentists, technicians, other health care professionals and office staff who are involved in taking care of you and your health.
- **Payment.** Includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care, except for genetic information that is PHI. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scene" plan functions such as risk adjustment, collection, or reinsurance.
- **Health care operations.** Includes activities by this Plan (and in limited circumstance other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Excludes genetic information that is PHI. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities and business planning and development.
- **To Business Associates.** The Plan may disclose your PHI to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.



**COUNTY OF SAN BERNARDINO, Active Employee's Self-Funded Dental PPO Plans**  
**Notice of Privacy Practices, July 27, 2013**  
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The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

**How the Plan may share your health information with the County of San Bernardino**

Cigna Dental may disclose your health information without your written authorization to The County of San Bernardino for plan administration purposes. The County of San Bernardino may need your health information to administer benefits under the Plan. The County of San Bernardino agrees not to use or disclose your health information other than as permitted or required by the Plan document and by law. The staff of the Human Resources Department, Employee Benefits and Services Division (EBSD) are the only County employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Cigna Dental and The County of San Bernardino, as allowed under the HIPAA rules:

- Cigna Dental may disclose "summary health information" to The County of San Bernardino if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- Cigna Dental may disclose to The County of San Bernardino information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that The County of San Bernardino cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by The County of San Bernardino from other sources, for example under the Family and Medical Leave Act, American's with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal and state laws).

**Other allowable uses or disclosures of your health information**

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' Compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonable able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonable believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public Health activities	Disclosures authorized by law to person who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you would not put you at further risk).
Judicial and Administrative Proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).



**COUNTY OF SAN BERNARDINO, Active Employee's Self-Funded Dental PPO Plans**  
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Law Enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

#### **Your individual rights**

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

- **Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse.** You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

- **Right to receive confidential communications of your health information.** If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.



**COUNTY OF SAN BERNARDINO, Active Employee's Self-Funded Dental PPO Plans**  
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If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

- **Right to inspect and copy your health information.** With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with one of these responses:

1. The access or copies you requested;
2. A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
3. A written statement that the time period for reviewing your request will be extended by no more than 30 days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

- **Right to amend your health information that is inaccurate or incomplete.** With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g. information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

1. Make the amendment as requested;
2. Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
3. Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.



**COUNTY OF SAN BERNARDINO, Active Employee's Self-Funded Dental PPO Plans**  
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- **Right to receive an accounting of disclosure of your health information.** You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six (6) years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

1. For Treatment, Payment or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. To family members or friends involved in your care (where disclosure is permitted without authorization);
6. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstance; or
7. As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

- **Right to obtain a paper copy of this notice from the Plan upon request.** You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

If you want to exercise the first five rights listed above, please contact **Cigna Dental** at (800) 238-5834. You will be provided with the necessary information and forms for you to complete and return, and Cigna Dental will advise the Plan of your request. In some cases, the Plan (or Cigna Dental as its Administrator) may charge you a nominal, cost-based fee to comply with your request.

#### **Changes to the information in this notice**

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on July 27, 2013. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice either electronically or by mail to your mailing address. If you receive this Notice electronically, you may also request a paper copy at no charge. This Notice is also posted on the County of San Bernardino, Human Resources Department website ([http://www.sbcounty.gov/hr/Benefits\\_Home.aspx](http://www.sbcounty.gov/hr/Benefits_Home.aspx)).

#### **Our right to check your identity**

For your protection, we may check your identity whenever you have questions about your specific enrollment Plan activities. We will check your identity whenever you submit requests to look at, copy or amend your records or to obtain a list of disclosures of your health information.



**COUNTY OF SAN BERNARDINO, Active Employee's Self-Funded Dental PPO Plans**  
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**Complaints**

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan Administrator, Cigna Dental or to the County of San Bernardino, Office of Compliance and Ethics at the addresses listed below. Alternatively you may complain to the Secretary of the U.S. Department of Health and Human Services, at the regional office that handles your area, generally within 180 days of when the act or omission occurred. You will not be retaliated against for filing a complaint.

<p>To file a complaint with the County of San Bernardino, Office of Compliance and Ethics:</p> <p>HIPAA Complaints Official          157 W. Fifth Street, First Floor          San Bernardino, CA 92415-0440</p> <p>Phone # (909) 387-4500          Fax # (909) 387-8950          Email: <a href="mailto:HIPAAComplaints@cao.sbcounty.gov">HIPAAComplaints@cao.sbcounty.gov</a></p>	<p>To file a complaint with the Plan as administered by Cigna Dental, contact:</p> <p>Connecticut General          P.O. Box 188037          Chattanooga, TN 37422</p> <p>Phone # (800) 238-5834</p>
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**For more information on the Plan's privacy policies or your rights under HIPAA, contact:**

HIPAA Benefits Analyst  
**County of San Bernardino,**  
 Human Resources Department  
 Employee Benefits and Services  
 157 W. Fifth Street, First Floor  
 San Bernardino, CA 92415-0440

Phone # (909) 387-5787  
 Fax # (909) 387-5566

**Connecticut General**  
 P.O. Box 188037  
 Chattanooga, TN 37422

Phone # (800) 238-5834

**Plans that will follow this Notice include the following:**

- County of San Bernardino, Active Employee's Self-Funded Dental PPO Plan #001-DPPO
- County of San Bernardino, Active Employee's Self-Funded Dental PPO Needles Plan #001 DPPO
- County of San Bernardino, Active Employee's Self-Funded Dental PPO Special Pay Plan #003 DPPO
- County of San Bernardino, COBRA Self-Funded Dental PPO Plan # 0004 DPPO



## CALIFORNIA LAW PROHIBITS WORKPLACE DISCRIMINATION AND HARASSMENT

The California Department of Fair Employment and Housing (DFEH) enforces laws that protect you from illegal discrimination and harassment in employment based on your actual or perceived:

- **Ancestry**
- **Age** (40 and above)
- **Color**
- **Disability** (physical and mental, including HIV and AIDS)
- **Genetic information**
- **Gender, gender identity, or gender expression**
- **Marital status**
- **Medical condition** (genetic characteristics, cancer or a record or history of cancer)
- **Military or veteran status**
- **National origin** (includes language use and possession of a driver's license issued to persons unable to prove their presence in the United States is authorized under federal law.)
- **Race**
- **Religion** (includes religious dress and grooming practices)
- **Sex** (includes pregnancy, childbirth, breastfeeding and/or related medical conditions)
- **Sexual orientation**

The California Fair Employment and Housing Act (Government Code sections 12900 through 12996) and its implementing regulations (California Code of Regulations, title 2, sections 11000 through 11141):

- **Prohibit harassment** of employees, applicants, unpaid interns, volunteers, and independent contractors by any persons and require employers to take all reasonable steps to prevent harassment. This includes a prohibition against sexual harassment, gender harassment, harassment based on pregnancy, childbirth, breastfeeding and/or related medical conditions, as well as harassment based on all other characteristics listed above.

- **Require that all employers provide information** to each of their employees on the nature, illegality, and legal remedies that apply to sexual harassment. Employers may either develop their own publications, which must meet standards set forth in California Government Code section 12950, or use a brochure from the DFEH.

- **Require employers with 50 or more employees and all public entities to provide sexual harassment and abusive conduct prevention training** for all supervisors.

- **Prohibit employers from limiting or prohibiting the use of any language** in any workplace unless justified by business necessity. The employer must notify employees of the language restriction and consequences for violation. Also prohibits employers from discriminating against an applicant or employee because he or she possesses a driver's license issued to a person who is unable to prove his or her presence in the United States is authorized under federal law.

- **Require employers to reasonably accommodate** an employee, unpaid intern, or job applicant's religious beliefs and practices, including the wearing or carrying of religious clothing, jewelry or artifacts, and hair styles, facial hair, or body hair, which are part of an individual's observance of his or her religious beliefs.

- **Require employers to reasonably accommodate employees or job applicants with a disability** to enable them to perform the essential functions of a job.

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- **Permit job applicants, unpaid interns, volunteers, and employees to file complaints** with the DFEH against an employer, employment agency, or labor union that fails to grant equal employment as required by law.

- **Prohibit discrimination** against any job applicant, unpaid intern, or employee in hiring, promotions, assignments, termination, or any term, condition, or privilege of employment.

- **Require employers, employment agencies, and unions** to preserve applications, personnel records, and employment referral records for a minimum of **two years**.

- **Require employers to provide leaves** of up to four months to employees disabled because of pregnancy, childbirth, or a related medical condition.

- **Require an employer to provide reasonable accommodations** requested by an employee, on the advice of her health care provider, related to her pregnancy, childbirth, or a related medical condition.

- **Require employers of 50 or more persons to allow eligible employees to take up to 12 weeks leave** in a 12-month period for the birth of a child; the placement of a child for adoption or foster care; for an employee's own serious health condition; or to care for a parent, spouse, or child with a serious health condition. The law also requires employers to post a notice informing employees of their family and medical leave rights.

- **Require employment agencies to serve all applicants equally**, refuse discriminatory job orders, and prohibit employers and employment agencies from making discriminatory pre-hiring inquiries or publishing help-wanted advertisements that express a discriminatory hiring preference.

- **Prohibit unions from discriminating** in member admissions or dispatching members to jobs.

- **Prohibit retaliation** against a person who opposes, reports, or assists another person to oppose unlawful discrimination.

**The law provides for remedies for individuals who experience prohibited discrimination or harassment in the workplace.** These remedies include hiring, front pay, back pay, promotion, reinstatement, cease-and-desist orders, expert witness fees, reasonable attorney's fees and costs, punitive damages, and emotional distress damages.

**Job applicants, unpaid interns, and employees:** If you believe you have experienced discrimination or harassment you may file a complaint with the DFEH.

**Independent contractors and volunteers:** If you believe you have been harassed, you may file a complaint with the DFEH.

Complaints must be filed within one year of the last act of discrimination/harassment or, for victims who are under the age of 18, not later than one year after the victim's eighteenth birthday.

For more information contact (800) 884-1684; TTY (800) 700-2320; videophone for the hearing impaired (916) 226-5285; [contact.center@dfeh.ca.gov](mailto:contact.center@dfeh.ca.gov); or [www.dfeh.ca.gov](http://www.dfeh.ca.gov).

Government Code section 12950 and California Code of Regulations, title 2, section 11013, require all employers to post this document. It must be conspicuously posted in hiring offices, on employee bulletin boards, in employment agency waiting rooms, union halls, and other places employees gather.

*In accordance with the California Government Code and ADA requirements, this publication can be made available in Braille, large print, computer disk, or voice recording as a disability-related accommodation for an individual with a disability. To discuss how to receive a copy in an alternative format, please contact the DFEH at the telephone numbers or e-mail address above.*



**“NOTICE B”****FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE**

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.
- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17½ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.
- Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.
- If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.
- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.
- Your employer may require medical certification from your health care provider before allowing you a leave for:
  - your pregnancy;
  - your own serious health condition; or
  - to care for your child, parent, or spouse who has a serious health condition.

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FAMILY CARE AND MEDICAL LEAVE AND PREGNANCY DISABILITY LEAVE  
Page 2

- See your employer for a copy of a medical certification form to give to your health care provider to complete.
- When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.
- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). The FEHA prohibits employers from denying, interfering with, or restraining your exercise of these rights. For more information about your rights and obligations, contact your employer, visit the Department of Fair Employment and Housing's Web site at [www.dfeh.ca.gov](http://www.dfeh.ca.gov), or contact the Department at (800) 884-1684. The text of the FEHA and the regulations interpreting it are available on the Department's Web site.

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# Equal Employment Opportunity is THE LAW

## Private Employers, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under Federal law from discrimination on the following bases:

### RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, protects applicants and employees from discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy), or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

### DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

### AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

### SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

### GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

### RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

### WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected:

The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at [www.eeoc.gov](http://www.eeoc.gov) or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at [www.eeoc.gov](http://www.eeoc.gov).

## Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

### RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

### INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

### DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within

three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

### RETALIATION

Retaliation is prohibited against a person who files a complaint of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at [OFCCP-Public@dol.gov](mailto:OFCCP-Public@dol.gov), or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

## Programs or Activities Receiving Federal Financial Assistance

### RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

### INDIVIDUALS WITH DISABILITIES

Section 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of the job.

If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.



# Notice to Employees:



**THIS EMPLOYER IS REGISTERED UNDER THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE AND IS REPORTING WAGE CREDITS THAT ARE BEING ACCUMULATED FOR YOU TO BE USED AS A BASIS FOR:**

## UI

### Unemployment Insurance

(funded entirely by employers' taxes)

When you are unemployed or working less than full time and are ready, willing, and able to work, you may be eligible to receive Unemployment Insurance (UI) benefits. There are three ways to file a claim:

#### Internet

File online with eApply4UI—the fast, easy way to file a UI claim! Access eApply4UI at <https://eapply4ui.edd.ca.gov/>.

#### Telephone

File by contacting a customer service representative at one of the toll-free numbers listed below:

English 1-800-300-5616	Spanish 1-800-326-8937
Cantonese 1-800-547-3506	Vietnamese 1-800-547-2058
Mandarin 1-866-303-0706	TTY (non voice) 1-800-815-9387

#### Mail or Fax

File by mailing or faxing UI Application, DE 11011, by accessing the paper application online at [www.edd.ca.gov/unemployment](http://www.edd.ca.gov/unemployment). The paper application can be filled out online and printed, or printed and completed by hand. Then the application can be mailed or faxed to an EDD office for processing.

**Note:** File promptly. If you delay in filing, you may lose benefits to which you would otherwise be entitled.

## DI

### Disability Insurance

(funded entirely by employees' contributions)

When you are unable to work or reduce your work hours because of sickness, injury, or pregnancy, you may be eligible to receive Disability Insurance (DI) benefits.

Your employer must provide a copy of Disability Insurance Provisions, DE 2515, to each newly hired employee and to each employee leaving work due to pregnancy or due to sickness or injury that is not job related.

To file a claim:

- **Online**, create an account at [www.edd.ca.gov/disability](http://www.edd.ca.gov/disability). This is the easiest and fastest way to file a new claim and obtain claim status information.
- **By mail**, obtain the data capturing Claim for Disability Insurance Benefits (Optical Character Recognition), DE 2501, from your employer, physician/practitioner, hospital, by calling us at 1-800-480-3287, or online at [www.edd.ca.gov/forms](http://www.edd.ca.gov/forms).

**Note:** If your employer maintains an approved Voluntary Plan for DI coverage, contact your employer for assistance.

FOR MORE INFORMATION ABOUT DI, PLEASE VISIT [www.edd.ca.gov/disability](http://www.edd.ca.gov/disability) OR  
CONTACT DI CUSTOMER SERVICE BY PHONE AT 1-800-480-3287.

STATE GOVERNMENT EMPLOYEES SHOULD CALL 1-866-352-7675.

TTY (FOR DEAF OR HEARING-IMPAIRED INDIVIDUALS ONLY) IS AVAILABLE AT 1-800-563-2441.

## PFL

### Paid Family Leave

(funded entirely by employees' contributions)

When you stop working or reduce your work hours to care for a family member who is seriously ill or to bond with a new child, you may be eligible to receive Paid Family Leave (PFL) benefits.

Your employer must provide a copy of Paid Family Leave Program Brochure, DE 2511, to each newly hired employee and to each employee leaving work to care for a seriously ill family member or to bond with a new child.

To file a claim:

- **Online**, create an account at [www.edd.ca.gov/disability](http://www.edd.ca.gov/disability). This is the easiest and fastest way to file a new claim.
- **By mail**, obtain the data capturing Claim for Paid Family Leave Benefits (Optical Character Recognition), DE 2501F, from your employer, physician/practitioner, hospital, by calling us at 1-877-238-4373, or online at [www.edd.ca.gov/forms](http://www.edd.ca.gov/forms).

**Note:** If your employer maintains an approved Voluntary Plan for PFL coverage, contact your employer for assistance.

FOR MORE INFORMATION ABOUT PFL, PLEASE VISIT [www.edd.ca.gov/disability](http://www.edd.ca.gov/disability) OR  
CONTACT CUSTOMER SERVICE BY PHONE AT 1-877-238-4373.

STATE GOVERNMENT EMPLOYEES SHOULD CALL 1-877-945-4747.

TTY (FOR DEAF OR HEARING-IMPAIRED INDIVIDUALS ONLY) IS AVAILABLE AT 1-800-445-1312.

**NOTE:** SOME EMPLOYEES MAY BE EXEMPT FROM COVERAGE BY THE ABOVE INSURANCE PROGRAMS. IT IS ILLEGAL TO MAKE A FALSE STATEMENT OR TO WITHHOLD FACTS TO CLAIM BENEFITS. FOR ADDITIONAL GENERAL INFORMATION, VISIT THE EDD WEBSITE AT [www.edd.ca.gov](http://www.edd.ca.gov).



## **NOTICE TO EMPLOYEES** **UNEMPLOYMENT INSURANCE BENEFITS**

This employer is registered under the California Unemployment Insurance Code and is reporting wage credits that are being accumulated for you to be used as a basis for unemployment insurance benefits.

### **If you are:**

- Unemployed, or
- Working less than full-time, AND
- You are ready, willing, and able to work full-time, or as instructed by the Employment Development Department,

### **You may be eligible to receive unemployment insurance benefits.**

Employees of Educational Institutions:

Unemployment Insurance benefits based on wages earned while employed by a public or nonprofit educational institution may not be paid during a school recess period if the employee has reasonable assurance of returning to work at the end of the recess period (California Unemployment Insurance Code Section 1253.3). Benefits based on other covered employment may be payable during recess periods if the unemployed individual is in all other respects eligible, and the wages earned in other covered employment are sufficient to establish an unemployment insurance claim after excluding wages earned from a public or nonprofit educational institution(s).

**NOTE:** Some employees may be exempt from unemployment and disability insurance coverage.

File your claim by telephone or Internet:

#### **Toll-Free Telephone Numbers**

<b>English 1-800-300-5616</b>	<b>Mandarin 1-866-303-0706</b>
<b>Spanish 1-800-326-8937</b>	<b>Vietnamese 1-800-547-2058</b>
<b>Cantonese 1-800-547-3506</b>	<b>TTY (Non Voice) 1-800-815-9387</b>

**EDD's Internet Address to Complete and Submit Your On-Line Application:**  
**<https://eapply4ui.edd.ca.gov>**

**Note:** If contacting us to file a claim, you must contact us by Friday to receive credit for the week. If calling, Mondays are our busiest days. For faster service, call Tuesday through Thursday.



# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

## Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness\*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.\*

**\*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

## Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months\*, and if at least 50 employees are employed by the employer within 75 miles.

**\*Special hours of service eligibility requirements apply to airline flight crew employees.**

## Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)

U.S. Department of Labor | Wage and Hour Division



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Human Resources  
Employee Benefits and Services  
157 West 5th Street, First Floor, San Bernardino, CA 92415-0440  
909.387.5787